

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 1 5 0 1	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbur John Adams						2a. DATE OF DEATH MONTH DAY YEAR April 9 1981		2b. HOUR 8 3/4 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 4 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
13. CITY OR TOWN OF DEATH Salisbury		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hoispital				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired employee		16. KIND OF BUSINESS OR INDUSTRY Shirt Company			
17a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Delaware		17b. COUNTY Sussex		17c. CITY OR TOWN Millsboro		17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		17e. STREET ADDRESS RFD #3, Box 356			
18. FATHER'S NAME FIRST MIDDLE LAST Wilbur Frisk Adams		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Jenkins									
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		19b. SOCIAL SECURITY NO. 213-18-4848		19c. INFORMANT ADDRESS Mrs. Mabel V. Adams (wife) same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) MASSIVE HEMOPTYSIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (b) (we) lost saw the deceased alive on _____, 19____, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did/did not) view the body after death.											
22b. SIGNATURE E. N. KLOPP M.D.		22c. DATE SIGNED 4/13/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD H. KLOPP							
22e. ADDRESS Salisbury, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/13/81		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Shad Point, Wic. Maryland					
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR APR 15 1981		25b. REGISTRAR'S SIGNATURE [Signature]							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE Turner ARDIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4---23-1981</b>			2b. HOUR <b>8:15</b> P M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 8, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pocomoke City, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.				
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SALISBURY NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Ardis</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Elizabeth Lankford</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>002-09-8045</b>		17. INFORMANT ADDRESS <b>Mrs. Naomi A. Ardis (wife) Same as 1.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease.</b>					
19a. DATE OF OPERATION <b>4/25/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/25/81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>U.S. 50-CIVIC AVE., SALISBURY, MD. 21801</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/25/81</b> 19 <b>81</b> to <b>4/23</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/23</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Earl M. Beardsley</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/24/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EARL M. BEARDSLEY, M.D.</b>		22e. ADDRESS <b>U.S. 50-CIVIC AVE., SALISBURY, MD. 21801</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/25/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Gardens Salisbury, Wic. Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. BURIAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>APR 27 1981</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

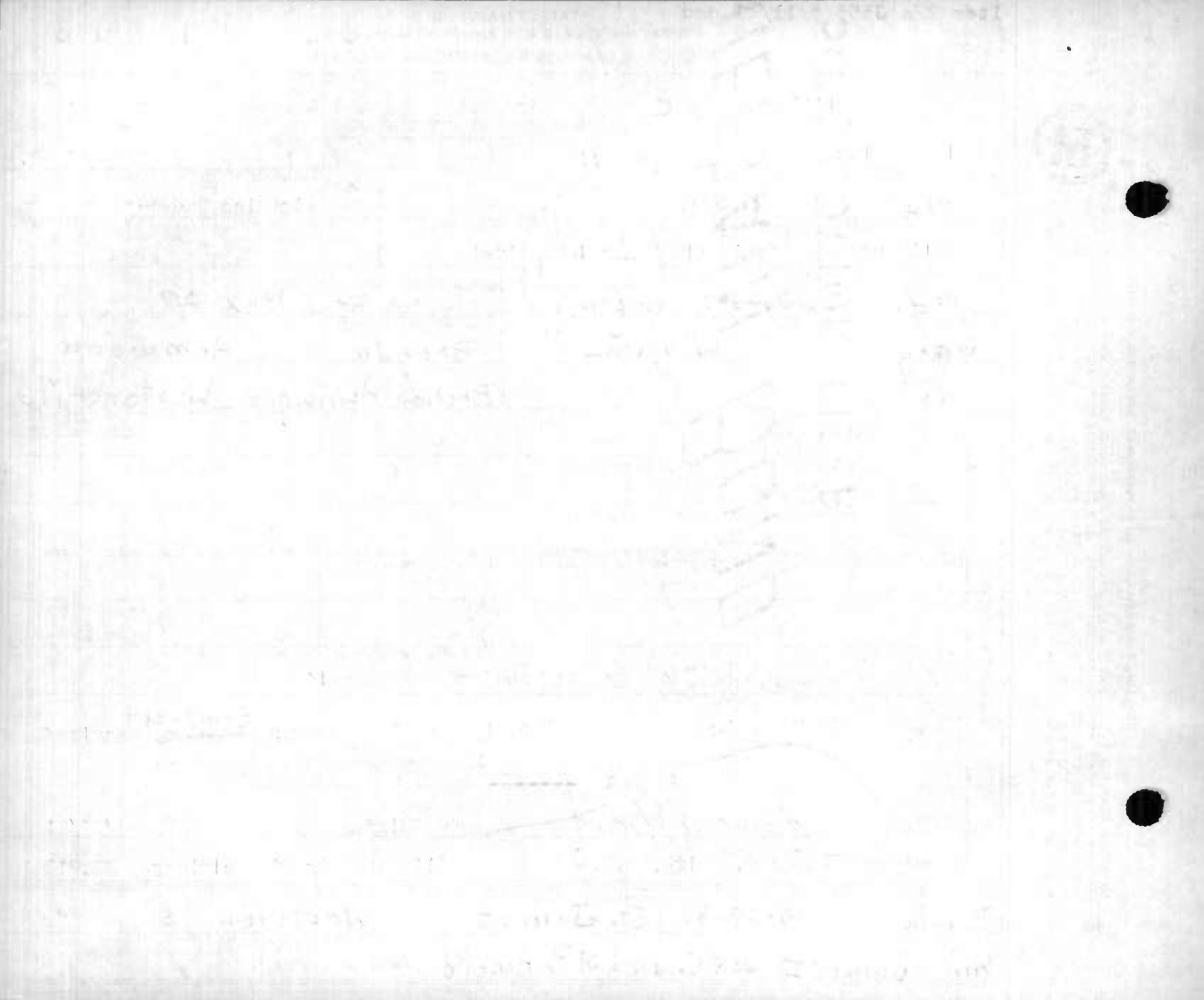
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DHMH-17  
(VR A15 ME (5))  
15M 2/80

Item 2a G5555 5/11/81 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST William MIDDLE C LAST Armwood		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 4 DAY 24 YEAR 19 81		2b. HOUR M
3 SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 10 DAY 23 YEAR 69	6. AGE (IN YEARS) LAST BIRTHDAY 11 YRS.	7c. DATE PRONOUNCED DEAD MONTH 4 DAY 24 YEAR 19 81
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.				
13b. CITY OR TOWN Westover				
13c. STREET ADDRESS Rt. 1 Box 27				
14. FATHER'S NAME FIRST Gary MIDDLE Williams LAST				
15. MOTHER'S MAIDEN NAME FIRST Brenda MIDDLE Armwood LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO.				
17. INFORMANT Brenda Armwood Westover, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9138 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 3:00 P.M. MONTH 4 DAY 24 YEAR 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN Rt. 1, Box 27, Westover, Wicomico, Maryland STATE Somerset
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Thomas D. Smith, M.D.		TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER		DATE SIGNED 4/26/81
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Baltimore, MD. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-29-81		23c. NAME OF CEMETERY OR CREMATORY St. James
24. FUNERAL DIRECTOR NAME Wm. H. James II		ADDRESS 258 Church St Pr. Anne Md		23d. LOCATION CITY OR TOWN Westover COUNTY S STATE Md.
25a. DATE REC'D BY REGISTRAR MAY 1 1981		25b. REGISTRAR'S SIGNATURE		



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 0 4			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Jill Christina AYDELOTTE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 4, 1981</b>		2b. HOUR <b>10<sup>20</sup> A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 23 1980</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>6 mo.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Pittsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Aydelotte</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tammie V. Cooper</b>		13e. STREET ADDRESS <b>Rt. 1, Box 170</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>George A. Aydelotte Rt. 1, Box 170 Pittsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>2776</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic Defect, Tricarboxylic acidemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost <b>saw</b> the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sid W. Atkinson</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/4/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sid W. Atkinson</b>		22e. ADDRESS <b>Somerset Medical Center, Princess Anne, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/7/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Berlin War, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Anna A. Barbaree</b>		ADDRESS <b>Berlin, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 9 1981</b>		25b. REGISTRAR'S SIGNATURE	



RECEIVED  
NOTICE NO. 2

WINTER WINTER

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

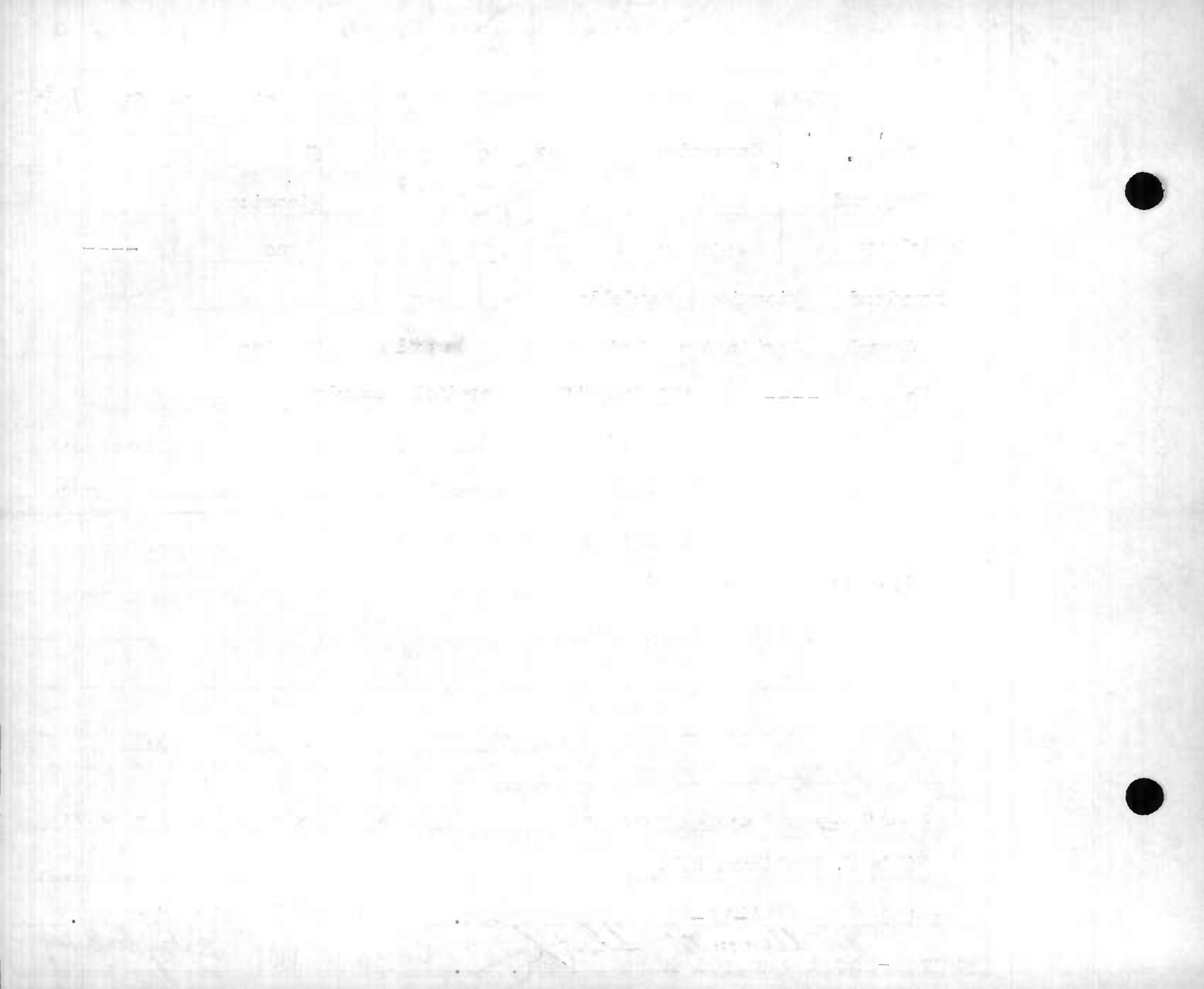
1 DECEASED NAME (TYPE OR PRINT) <b>WILSON HUNTER BAILEY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>04 15 81</b>			2b HOUR <b>1036</b> M				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>03 06 17</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsular General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a STATE <b>Maryland</b>			13b CITY OR TOWN <b>Wicomico</b>		13c CITY OR TOWN <b>Mardella</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Washington Bailey</b>			15 MOTHER'S MAIDEN NAME MIDDLE LAST <b>Nettie Hopkins</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-82-0047</b>		17 INFORMANT ADDRESS <b>Hospital Records</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive Heart Attack</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis BVD.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension, essential,</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-22-76</b> , 19 <b>81</b> , to <b>4-15</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>4-15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Hilda I. Houlihan</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>4-15-81</b>		
22e PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hilda I. Houlihan, M.D.</b>					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-18-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mardela Wicomico Md.</b>			
24. FUNERAL DIRECTOR NAME <b>William M. Marvel-Short</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 21 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8111506			
1. DECEASED NAME (TYPE OR PRINT) <b>Daniel Norris Barber Jr</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 3, 1981</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 7, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>x5 47</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12. USUAL OCCUPATION (IF NOT WORKING FOR MOST OF WORKING LIFE, GIVE REASON) <b>General Elevator Repairman</b>		13. KIND OF BUSINESS OR OCCUPATION <b>Retired Superintendent</b>	
13a. STATE <b>Delaware</b>		13b. COUNTY		13c. CITY OR TOWN <b>Selbyville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Norris Barber Sr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Adelaide E Kilchenstein</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			
16b. SOCIAL SECURITY NO. <b>212-30-3996</b>		17. INFORMANT <b>Mrs Laura K Rimkis</b>		18. ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart Disease</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/3 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> 19 <b>81</b> , to <b>4/3</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>4/3</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death)							
22b. SIGNATURE <b>J. H. Ruffe Ho</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>4/3</b>		22d. ADDRESS <b>Q G W Med Center</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/7/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>APR 6 1981</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Indicate General Capital

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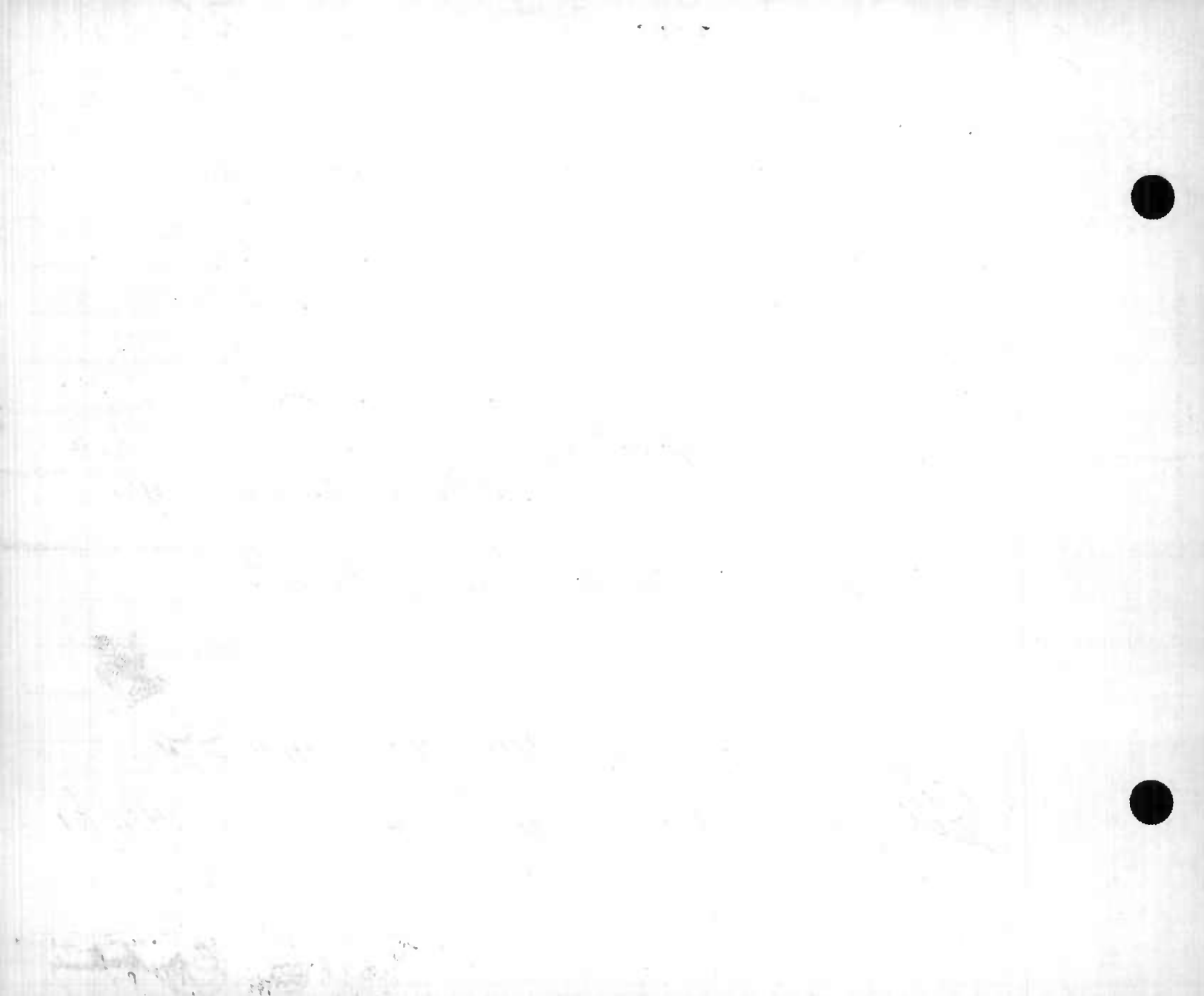


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 1 5 0 7	
1- FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
James Gordy BEACH				4-11-81				8:15		A.M.	
3. SEX.		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS	
M		W		6-30-98		82 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury, Md.		Salisbury Nursing Home				Auto Dealer					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Maryland				Wicomico		Hebron		307 N. Main Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
James Frank Beach				Margaret Elizabeth Owens							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				220-32-0881A		(son)		502 Baltimore Ave. Mr. James G. Beach, Towson, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aspiration pneumonia</i> 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Carcinoma of prostate &amp; metastasis</i> (c) <i>Chronic obstructive lung disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> 19 <i>79</i> , to <i>4/11</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/11</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.				22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. ADDRESS		22d. DATE SIGNED	
DR. EARL M. BEARDSLEY				Civic Ave, Salisbury, Md. 21801						4/11/81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/14/81		Springhill Memory Gardens, Salisbury, Md.		Maryland			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS				25. DATE REC'D. BY REGISTRAR (REGISTERED IN SIGNATURE)			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland								APR 16 1981			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
MINNIE L. Benson		APRIL 30, 1981		3:40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
female	white	Jan. 16, 1908	73 YRS.	IF UNDER 24 HRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Wicomico MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		housewife		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Worcester	Pocomoke	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	R.F.D. 2	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John Thomas Hall		Amanda Stephens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		220-26-0900	R.F.D. 2, Box 320 Emma Lee Benson Pocomoke City, Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Pneumonia Respiratory Failure</u>					
4939 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchial Asthma</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Benito S. Chan MD</u> DEGREE		22c. DATE SIGNED <u>4/30/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BENITO S. CHAN		547-D Riverdale Drive			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	5/2/81	First Baptist Cem.	Pocomoke Worcester Md.		
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE	
Scott S. Melton		MAY 7 1981			
ADDRESS					
Pocomoke City, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (if any) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8111509			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM BOWDOIN Bloxom					April 18, 1981							9:05 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Mar. 14, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY NASA					
13a. STATE Virginia			13b. COUNTY Accomack		13c. CITY OR TOWN Parksley		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
14. FATHER'S NAME FIRST MIDDLE LAST Sewell Bloxom					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Ewell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W. W. II 227-24-0844		17. INFORMANT ADDRESS Orman O. Bloxom Wallops, Virginia									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal pneumonia</u> <u>1850</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastatic Carcinoma</u> (c) <u>Carcinoma of prostate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>98 hr.</u> <u>1975</u> <u>1973</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17/81</u> to <u>4/18/81</u> , that (I) (we) last saw the deceased alive on <u>4/17/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John J. Williams</u>					DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/18/81</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/81		23c. NAME OF CEMETERY OR CREMATORY Parksley Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Parksley, Accomack, Va.					
24. FUNERAL DIRECTOR NAME <u>John J. Williams</u>					24b. ADDRESS P. O. Box 527 Parksley, Va.								

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ALMA M. BOUIS		4 3 81		8:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
FEMALE	WHITE	1 8 1898	83	BALTIMORE CITY OR COUNTY OF DEATH	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
MD.	U.S.A.	SALISBURY	SALISBURY NURSING HOME	HOUSEWIFE	-----
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.	Worcester	Ocean City	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	610 Philadelphia Ave.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Charles	Barbara				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	217-48-1503	Mr. Carl Kirby	33808		
		4235 W. Tradewinds Ave. Lauderdale Fla.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>					<i>1 wk.</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i>					<i>yr.</i>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<i>Renal COAS.</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>4/30</i> 19 <i>79</i> to <i>4/3</i> 19 <i>81</i> that (I) (we) last saw the deceased alive on <i>4/3</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) attend the body after death.					
22b. SIGNATURE (TYPE)	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<i>Dr. Earl Beardsley</i>	<i>MD</i>	<i>6</i>			<i>4/4/81</i>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	4-6-81	Druid Ridge Cemetery	Pikesville Balto. COUNTY Md.		
24. FUNERAL DIRECTOR	25a. DATE RECEIVED BY REGISTRAR	25b. SIGNATURE			
Loring Byers Funeral Directors P.A. 8728 Liberty Rd. Randallstown, Maryland 21133	APR 7 1981	<i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

BP

RECEIVED  
JAN 21 1961

NOT RECORDED

1961 T 844



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lydia MAE BRISCOE</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 16, 1981</b>		2b. HOUR <b>9:45 A M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 28 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PHILADELPHIA, PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher/Aide</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Day Care Cntr.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>QUANTICO</b>		13e. STREET ADDRESS <b>ROUTE #1, BOX 180</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN WHITTINGTON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HATTIE COULBOURNE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-14-9663</b>		17. INFORMANT ADDRESS <b>MRS. RACHEL HULL same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4392</b> IMMEDIATE CAUSE (a) <b>Acc. CVT &amp; @ hemiplegia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Pseud)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Y</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Lymphosarcoma</b>											
19a. DATE OF OPERATION <b>12/24/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/80</b> , 19____, to <b>04/16/81</b> , 19____, that (I) (we) lost the deceased alive on <b>04/16/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L.V. Maldve</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>04/16/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L.V. Maldve, M.D., F.A.G.S.</b>				22e. ADDRESS <b>Deer's Head Center, Salisbury, Md. 21801</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/20/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HULL'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WETIPQUIN WICOMICO MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>JOLLEY MEMORIAL CHAPEL</b>				24b. ADDRESS <b>JERSEY ROAD SALISBURY, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

HP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 11512

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Aubrey Hessler BROWN		APRIL 7 1981		11 <sup>55</sup> AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	July 31, 1907	73	Wicomico	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Cleveland, Ohio	USA		Wicomico		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury	Peninsula General Hospital	Maintenance foreman	Town Housing		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Conn.	New London	Norwich	YES <input type="checkbox"/> NO <input type="checkbox"/>	157 Hickory Street	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			
Paul	Emma	No			
16a. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS			
046-28-6757	Mrs. Marion S. Brown (wife)	same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Dissecting descending aortic aneurysm</u>					
4410 DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Hypertension</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> 19 <u>81</u> , to <u>4/7</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/7</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>J. Z. Badros, M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JOSEPH Z. BADROS MD		229 FLORIDA AVE SALISBURY, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/11/81		Divine Providence Cem. Norwich, New London, Conn.	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR			
NAME ADDRESS		APR 15 1981			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland					

MEDICAL CERTIFICATION

Indicate the date of the report

(M)

11/1/54

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 5 1 3  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Burnette</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-3-81</b>		2b. HOUR <b>4:50AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-11-04</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>76</b>		IF UNDER 24 HRS. HOURS MIN. <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wenona, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County</b>		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired-laborer</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Campbell soup</b>	
12. CITY OR TOWN OF DEATH <b>Salisbury</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Salisbury Nursing Home</b>		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Somerset</b> 13c. CITY OR TOWN <b>Wenona</b>	
15. FATHER'S NAME FIRST MIDDLE LAST <b>George Burnette</b>		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Robinson</b>		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prekial Hematomis</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>generalized arterio sclerosis</b> (c) <b>generalized arterio sclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>4 yrs.</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <b>arterio sclerosis cardiovascular disease</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) notified the deceased from <b>8/1</b> <b>8/11</b> , 19 <b>78</b> , to <b>4/3</b> , 19 <b>81</b> , that (i) (we) lost <b>4/2</b> (a) the deceased alive on <b>4/2</b> (b) (did not lose the body after death)		22b. SIGNATURE <b>DR. EARL M. BEARDSLEY</b>		22c. DEGREE <b>MD</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>CIVIC AVE. RT. 50 SALISBURY, MD.</b>		22f. DATE SIGNED <b>4/3/81</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley U.M. Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Deal Island Somerset Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Jolley Memorial Chapel</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Earl M. Beardsley</b>		25c. REGISTRAR'S NAME <b>Earl M. Beardsley</b>		25d. REGISTRAR'S ADDRESS <b>Salisbury, Maryland</b>	

**RETURN TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**MEDICAL CERTIFICATION**

5  
(21)

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8111514				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DORTHY BURTON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 19, 1981</b>				2b. HOUR <b>5:30 PM</b>
3. SEX <b>FEMALE</b>		4. RACE <b>AFR</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 22 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD Wico</b>		13c. CITY OR TOWN <b>Salis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1104 Kross AVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>OSCAR Wilson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Jones Waller</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-03-5112</b>		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>carcinoma of stomach</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (the hospital) attended the deceased from <b>April 17, 1981</b> to <b>April 19, 1981</b> , that (1) (the) last saw the deceased alive on <b>April 19, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rodney A. Wernich</b>					DEGREE <b>MD.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/19/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RODNEY A. WERNICH</b>					22e. ADDRESS <b>KAY AVE. SALISBURY MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-27-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACERS MEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salis Wico MD</b>			
24. FUNERAL DIRECTOR NAME <b>Russell Fooks</b>					ADDRESS <b>Salisbury</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Russell Fooks</b>

BP \_\_\_\_\_

1981

1981

1981

APR 27 1981



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VRA 15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11515	
1. DECEASED NAME (TYPE OR PRINT) <b>L. Carroll Carey</b>										2a. DATE KNOWN OF DEATH <b>4-25-81</b>										2b. HOUR <b>1p</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10 25 11</b>		6. AGE (IN YEARS) <b>69</b>		IF UNDER 1 YR. <b>6</b> MONTHS <b>0</b> DAYS		IF UNDER 24 HRS. <b>0</b> HOURS <b>0</b> MIN.		2c. DATE PRONOUNCED DEAD <b>4-25-81</b>		2d. HOUR <b>1p</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>									
10. CITY OR TOWN OF DEATH <b>Sharptown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rural Route</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Perdue Inc. Poultry</b>				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INCLUDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. STREET ADDRESS <b>107 State Street</b>									
14. FATHER'S NAME <b>John W. Carey</b>										15. MOTHER'S MAIDEN NAME <b>Mamie Phillips</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>222-05-8542</b>				17. INFORMANT ADDRESS <b>Elizabeth B. Carey Sharptown, Md.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>cerebrovascular accident</b> IMMEDIATE CAUSE (a) <b>4360</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>hypertension, cerebral vascular insufficiency</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>John T. Bulkeley</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>4-26-81</b>				M.D. <b>Deputy</b> MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <b>John T. Bulkeley</b>				ADDRESS <b>Salisbury, Maryland 21801</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-28-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>											
24. FUNERAL DIRECTOR NAME <b>William M. Short</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 1 - 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Barney Kennedy</b>													

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Male White 10 21 63

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Weyland Wisconsin  
107 7th Street

30 min.  
years  
cerebrovascular accident  
generalized arteriosclerosis

hypertension, cerebral vascular insufficiency

John T. Quakeley  
Selfish, Weyland  
4-25-81

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DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer's death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8111516			
1. DECEASED NAME (TYPE OR PRINT) <b>J. HRONA A. CARTER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 12, 1981</b>		2b. HOUR <b>6:37 PM</b>	
3. SEX <b>F</b>	4. RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 17 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>SOM.</b>	13c. CITY OR TOWN <b>DEAL ISLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>MAIN ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ZACHARIAH CARTER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOTTIE HUGHES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-07-1327</b>		17. INFORMANT <b>DONALD CARTER</b>		ADDRESS <b>156 CRAIG AV NEW YORK, N.Y. 11550</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Anteroseptal Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4029</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>19 76</b> to <b>4/12</b> 19 <b>76</b> , that (I) (the) last saw the deceased alive on <b>4/12</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Donald M. Woods</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/13/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD M. WOODS</b>		22e. ADDRESS <b>SALISBURY MD 21801</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/16/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DEAL ISLAND MD 21824</b>	
24. FUNERAL DIRECTOR <b>Leroy Webster</b>		RT 3 - 1304 354 ADDRESS <b>PRINCESS ANNE MD 21853</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Leroy Webster</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11517	
1. FOR STATE REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		HAROLD		B.		COLEMAN		4-16-81		10:35 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Male	White	6 24 33	47 YRS.			4-16-81		19		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Florida		U. S.		NEVER MARRIED		Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital		Laborer							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Somerset		Princess Anne		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 2, Box 251-B			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Harold		Coleman, Sr.		no		227-34-2139		Mrs. Joyce Anne Coleman		Princess Anne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Bullet Wound of Brain</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>9554</b>										days	
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		6:30 AM 4-12-81		Self-inflicted gun wound.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		own home		Rt. 2, Princess Anne, Somerset, Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Earl L. Royer, M.D.		Deputy		4-16-81							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		4/20/81		Beechwood		Princess Anne, Somerset, Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hinman Funeral Home, Princess Anne, Md.		APR 21 1981									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 5 1 8 CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) NEVER SIEA J Corbin					2a. DATE OF DEATH MONTH DAY YEAR April 11, 1981			2b. HOUR 5:15 PM	
3. SEX Male		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 9 13 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 3 Bx 213 WALSTON SWITCH	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE B				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES CORBIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 814-32-2145A		17. INFORMANT ADDRESS Helen BIVANS - SALIS. MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Car Poolman APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Supraventricular Tachycardia Advanced Rheumatoid Arthritis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/22 19 81, to 4/11 19 81, that (I) (we) last saw the deceased alive on 4/10 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Selva M. Baldado					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS West Funeral Home SALIS MD			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		APR 16 1981		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8111519			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM "JACK" HENRY DENNIS				2a. DATE OF DEATH MONTH DAY YEAR April 15 1981		2b. HOUR 2:30 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 29 00		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEWARK, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY farmer	
13a. STATE MARYLAND				13b. CITY OR TOWN NEWARK		13c. STREET ADDRESS ROUTE 1 BOX 58	
14. FATHER'S NAME FIRST MIDDLE LAST ISSAC JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA DENNIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-20-3613		17. INFORMANT CLIFTON H. DENNIS		ADDRESS SAME AS ABOVE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive Heart failure</u> (c) <u>Congestive Cardiomyopathy</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN STREET COUNTY STATE			
22a. I certify that I (the hospital) attended the deceased from <u>4/9/81</u> 19 to <u>4/15/81</u> 19 that I saw the deceased alive on <u>4/15/81</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)				22b. SIGNATURE Clayton L. Raab M.D.		22c. DATE SIGNED 4/15/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton L. Raab M.D.		22e. ADDRESS Lousie & Quincey St's Salisbury, Mo.		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/18/81		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WORCESTER MD	
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL		ADDRESS SALISBURY, MARYLAND		25a. DATE REC'D. BY REGISTRAR APR 27 1981		25b. REGISTRAR'S SIGNATURE Anthony K. B. [Signature]	

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth E. DICK EY</b>			2a. DATE OF DEATH MONTH <b>APR 12</b> DAY <b>3</b> YEAR <b>1991</b>		2b. HOUR <b>10<sup>40</sup> A.M.</b>
1. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>DEC.</b> DAY <b>16</b> YEAR <b>1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cum Nunc</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>CAMELOT Apts</b>	
14. FATHER'S NAME FIRST <b>GUSTF</b> MIDDLE <b>R.</b> LAST <b>ERICKSON</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARIA</b> MIDDLE <b>W.</b> LAST <b>NEEDIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>222-42-5272</b>		17. INFORMANT NAME <b>Dr. Robert L. Dickey</b> ADDRESS <b>416 Pine Bluff Rd Salisbury Md</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>87</b> , to <b>4/3</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. R. L. Dickey</b> DEGREE <b>MD</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R. L. Dickey</b>				22e. ADDRESS <b>PGH</b>	
23a. BURIAL, CREMATION, REMOVAL BY <b>CREMATION</b>		23b. DATE <b>4/6/91</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hockessin Crematory</b>	
23d. LOCATION CITY OR TOWN <b>Hockessin</b> COUNTY <b>Del.</b> STATE <b>Del.</b>		23e. FUNERAL DIRECTOR NAME <b>Hill-Baker-Burds</b> ADDRESS <b>Salisbury Md</b>			
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Burds</b>				25. REGISTRAR'S SIGNATURE <b>APR 17 1991</b>	



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8111521			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 20 HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada E. Donohue				2a. DATE OF DEATH MONTH DAY YEAR 20 HOUR April 28, 1981 5:15 M			
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 7-29-07		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Fruitland 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 304 Pine St.							
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Hargis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-07-6607		17 INFORMANT ADDRESS SYLVIA FLEMING 836 SHUMAKER DR.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 Cerebral hemorrhage, massive							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Hypertension							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) diabetes, obesity							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 4/23/81 to 4/28/81, that (2) we lost saw the deceased alive on 4/28/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (he) (she) (it) (did) (did not) view the body after death.							
22b. SIGNATURE Alberta Polin				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (BY) Burial		23b. DATE 5-2-81		23c. NAME OF CEMETERY OR CREMATORY STANFORD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Fruitland Wico. Md.	
24 FUNERAL DIRECTOR NAME Clinton F. Stewart				ADDRESS West Rd Salis. Md.		25a. DIRECTED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCISE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11522	
1. DECEASED (TYPE OR PRINT) <b>AKA Bennie Guy Dorsey</b> <b>BENJAMIN HARDGRAY DORSEY</b>		2a. DATE OF DEATH <b>4-8-81</b>		2b. HOUR <b>2:15A</b>		2c. DATE OF DEATH <b>4-8-81</b>		2d. HOUR <b>"</b>		2e. MONTH <b>4</b>	
3. SEX <b>Male</b>		4. RACE <b>AA</b>		5. DATE OF BIRTH <b>10-17-1914</b>		6. AGE (IN YEARS) <b>66</b>		7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>112 Newport Circle</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Pulp wd</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>112 Newport Circle</b>			
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>Dorsey</b> LAST <b>Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Maggie</b> MIDDLE <b>Smith</b> LAST <b></b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16a. SOCIAL SECURITY NO. <b>213-22-6819</b>				17. INFORMANT <b>Mary D. Fields</b>				18. ADDRESS <b>403 Purnell St. Salisbury, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>8902</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2 xx 4-8-81</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>House fire.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>own/home</b>		21f. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>112 Newport Circle, Salisbury, Wic., Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Earl L. Royer</b>		TITLE (SPECIFY) <b>Deputy</b>						DATE SIGNED <b>4-9-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>		ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-12-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Groton Cemetery</b>				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Messongo, VA</b>			
24. FUNERAL DIRECTOR <b>Funeral Home, Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Earl L. Royer</b>							







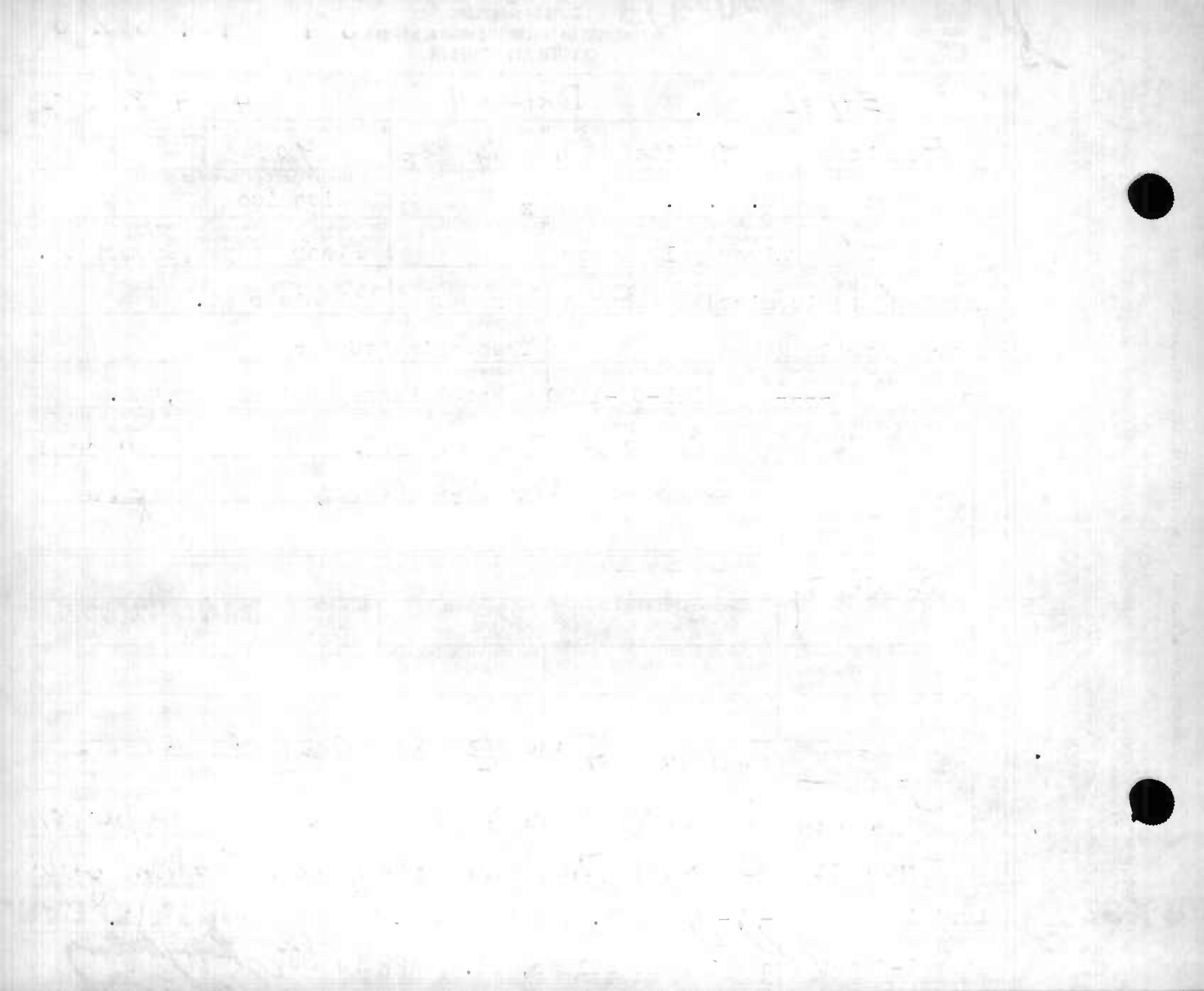
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 1 5 2 3  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Ethel M. Driscoll		MONTH DAY YEAR 4 14 81	
3 SEX		2b. HOUR	
Female		318 AM	
4 RACE		5. AGE (IN YEARS LAST BIRTHDAY)	
White		92 YRS.	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Delaware		U. S. A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. BALTIMORE CITY OR COUNTY OF DEATH	
Salisbury		Wicomico MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Salisbury		River Walk Manor	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Floor Lady		Garnet Co.	
13a. STATE		13b. COUNTY	
Maryland		Wicomico	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Whitehaven		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST George Martin Hearn		FIRST MIDDLE LAST Theodosia LeCates	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		221-03-1190	
17. INFORMANT		ADDRESS	
Hazel Kenney Whitehaven, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4340 Cerebral Thrombosis		11 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarct		years	
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
Senility			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY	
<input type="checkbox"/>		HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED		21b. PLACE OF INJURY	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	
21c. HOW INJURY OCCURRED		21d. LOCATION	
[ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]		CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from Jan 12 19 81, to April 14 19 81, that (we) last saw the deceased alive on April 14 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	
Thomas C. Hill Jr.		M.D.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS	
THOMAS C. Hill Jr.		Pine Bluff Road, Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		4-17-81	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
St. Stephens Cem.		CITY OR TOWN COUNTY STATE Delmar Sussex Del.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS Marvel Short Funeral Home Delmar, De.		25b. REGISTRAR'S SIGNATURE APR 20 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

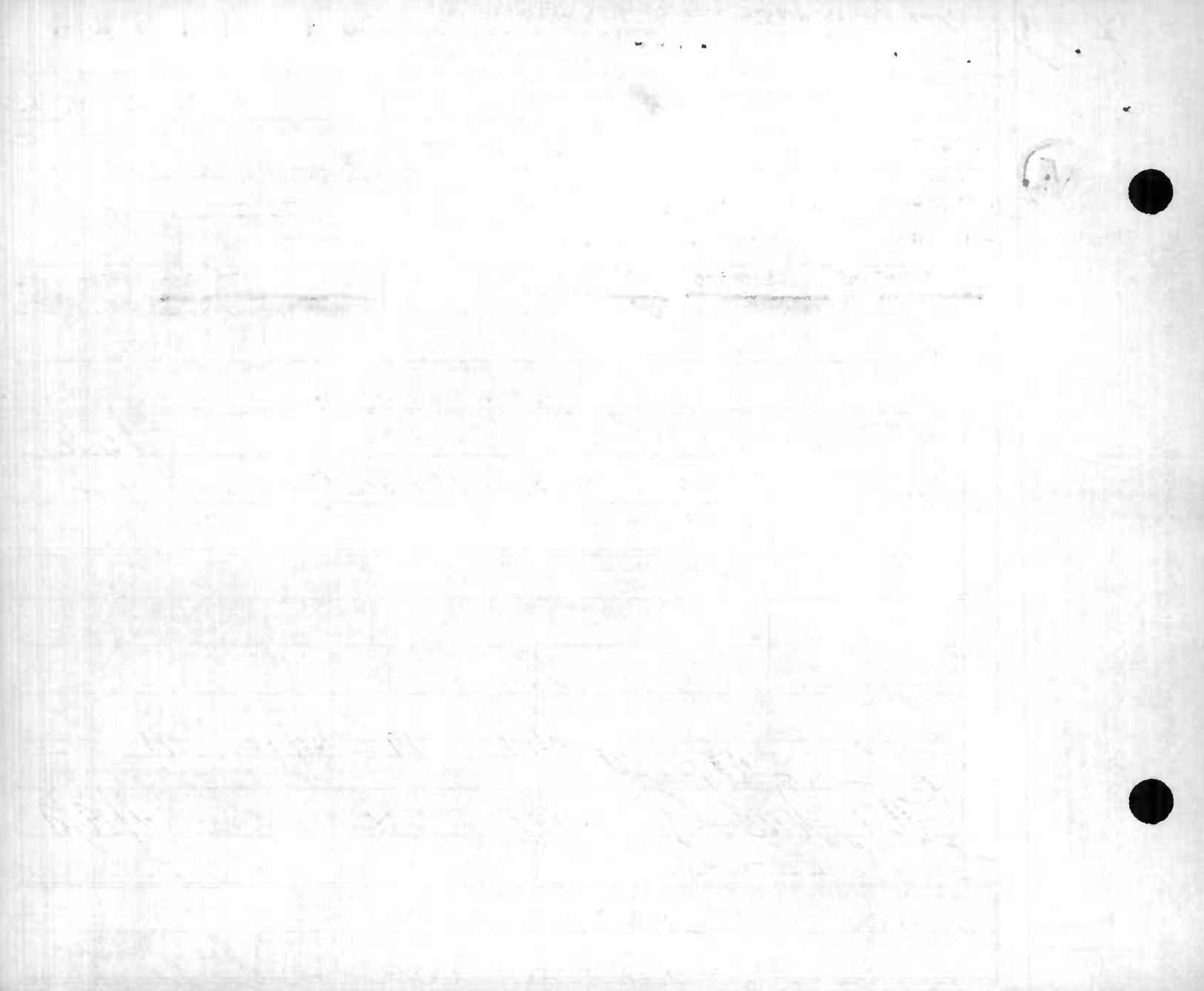
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

Items #13a-13e Film G556 6/17/81 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE Ann DUTCHER</b>			2a. DATE OF DEATH MONTH <b>4</b> DAY <b>18</b> YEAR <b>81</b>			2b. HOUR <b>6:00 A.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MO <b>10</b> DAY <b>28</b> YEAR <b>89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO MD.</b>		
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SALISBURY NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE WHERE ADMITTED) <b>New Jersey Burlington Co. Holly</b>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>320 Glen Garden Apt. 85 Madison Ave. 202</b>		
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Pierce</b> LAST <b>Pierce</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Sheerin</b> LAST <b>Sheerin</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>136-36-9870</b>		17. INFORMANT (daughter) ADDRESS <b>Mrs. Margaret D. Gilman, Salisbury, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) <b>due to or as a consequence of</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>yes</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> 19 <b>79</b> to <b>4/18</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/17</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE <b>Earl M. Beardsley</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>4/19/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EARL M. BEARDSLEY, M.D.</b>		
22e. ADDRESS <b>U.S.50-CIVIC AVE., SALISBURY, MD. 21801</b>				22f. DATE REC'D. BY REGISTRAR				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4/ 20/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes, Sussex, Delaware</b>		
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Rafael M. Beardsley</b>		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Ester Dye			2a. DATE OF DEATH MONTH DAY YEAR April 16, 1981			2b. HOUR M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Onancock, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 420 W. College Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none		
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 420 W. College Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas C. Bull			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malisha Joynes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 213-74-3203		17. INFORMANT (daughter) ADDRESS Mrs. Jeanette Knoop, Baltimore, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroselectic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Rheumatoid Arthritis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1955 to April 18, 1981, that (I) (we) last saw the deceased alive on April 12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David J. Gilmore, M.D.					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/18/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David J. Gilmore, M.D.					22e. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/18/81		23c. NAME OF CEMETERY OR CREMATORY Mt. Holly Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Onancock, Virginia			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR APR 21 1981		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11526			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN H. EIFERT</b>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>4-10-81</b>		2b. HOUR P M <b>P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 27 04</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>77</b>		IF UNDER 1 YR. MONTHS DAYS <b>1 13</b>		IF UNDER 24 HRS. HOURS MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>			
10. CITY OR TOWN OF DEATH <b>Delmar</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>201 E. Elizabeth St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. S. P. Skinner Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Delmar</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>201 E. Elizabeth St.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William G. Eifert</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgie Eifert</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>196-07-2805</b>		17. INFORMANT ADDRESS <b>Jill Barbon Salisbury, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>[Signature]</i>						TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>4-13-81</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>						ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-14-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore City Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Marvel-Short, Delmar, De.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 15 1981</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

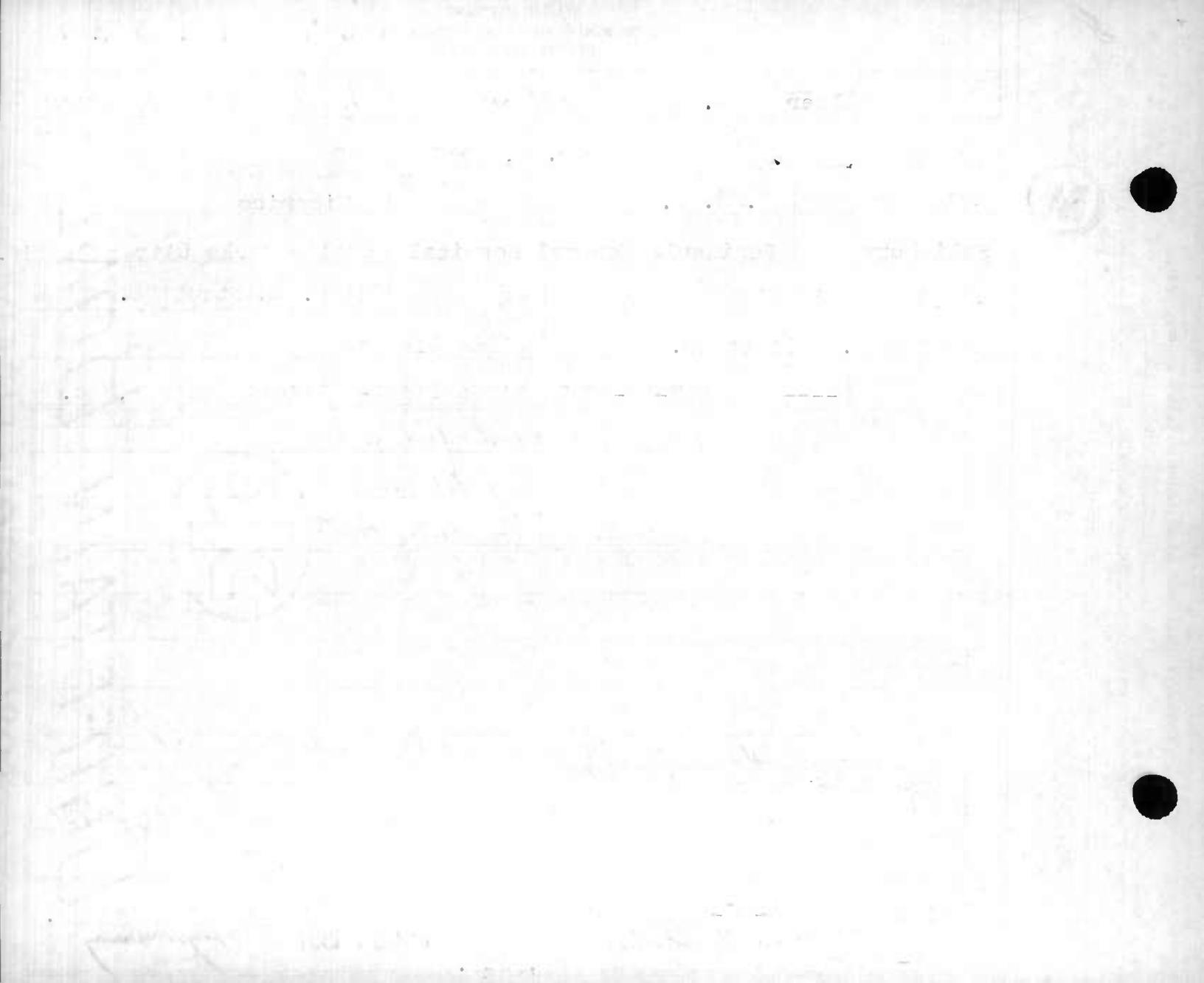
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	1	5	2	7
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Elmer O. Elliott										2a. DATE OF DEATH MONTH DAY YEAR April 23, 1981				2b. HOUR 12:30 P.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Mar. 3, 1932			6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 1 20		8. IF UNDER 24 HRS. HOURS MIN. 12 30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.							
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Works			12b. KIND OF BUSINESS OR INDUSTRY City of Salis.			
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Delmar			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 604 E. Chestnut St.					
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Elliott Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Tingle										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----			17. INFORMANT ADDRESS Hilda Tingle Elliott Delmar, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia &amp; renal failure</u> <u>1561</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia &amp; renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the bile duct</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>81</u> , to <u>4/23</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.																
22b. SIGNATURE <u>Philip A. Insley</u>						DEGREE <u>MD</u>				22c. DATE SIGNED <u>4/23/81</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Philip A. Insley</u>						22e. ADDRESS <u>Medical Center</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-26-81		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.						
24. FUNERAL DIRECTOR NAME <u>William M. Short</u>						24b. DATE REC'D. BY REGISTRAR <u>APR 27 1981</u>				24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>						
Marvel-Short Funeral Home Delmar, Del.																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 1 5 2 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Lee Etta Elliott</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>April 08, 1981</u>				2b. HOUR <u>12:10pm</u>	
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>July 4 1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>SALISBURY WICOMICO MD.</u>					
10. CITY OR TOWN OF DEATH <u>SALISBURY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Deers Head Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laundry Operator</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		
13a. STATE <u>Md.</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Berlin</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>102 Buckingham Rd.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Jesse - Layton</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mamie - Bradford</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>221-20-8803</u>		17. INFORMANT ADDRESS <u>Charles W. Elliott 102 Buckingham Rd. Berlin, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial Intestinal Obstruction Secondary to</u> <u>5621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Severe fecal Impaction</u> <u>Severe Diverticulosis</u> (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>End-stage Kidney Disease Secondary to Nephrosclerosis</u>											
19a. DATE OF OPERATION <u>2/3/81</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Kidney Disease</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>81</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>544-D Riverside Drive Berlin Worcester Md.</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>81</u> , to <u>4/8</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Benito S. Chan</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/8/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BENITO S. CHAN</u>				22e. ADDRESS <u>544-D Riverside Drive</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>4/11/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Berlin Worcester Md.</u>			
24. FUNERAL DIRECTOR <u>Arnold A. Burbage</u>				ADDRESS <u>Berlin, Md.</u>				25. DATE RECD. BY REGISTRAR <u>APR 13 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be asked at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. HOUR	
John Robert Fanning								5:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		12 01 15		65 YRS			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Wicomico MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				Stereotyper		Office U.S. Printing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Virginia		Accomack		Painter		Painter, Virginia 23420			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Frederick M. Fanning					Emma L. Lang				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)									
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> W.W. # 2									
16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
213-03-2701					Kathryn M. Fanning Painter, Va. 23420				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of Lung</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Old TB</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>3/10</u> 19 <u>81</u> , to <u>4/1</u> 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>3/31</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>J. D. Meadows</u>					22c. DATE SIGNED <u>4/3/81</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. D. Meadows M.D.</u>					22e. ADDRESS <u>Suite 31 Wesley Dr. Salisbury MD</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		4-6-1981		Culpeper Natinal Cem.		Culpeper, Va.			
24. FUNERAL DIRECTOR NAME <u>Guy J. Doughty</u>					25a. DATE REC'D. BY REGISTRAR <u>APR 16 1981</u>				
P.O. Box 633 Exmore, Va.					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



Winnipeg

Penitentiary & General Hospital

Winnipeg

RECEIVED  
JAN 17 1911  
PENITENTIARY & GENERAL HOSPITAL  
WINNIPEG

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 3 0	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIRGINIA ISABEL FISHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 28 1981</b>		2b. HOUR <b>3:30 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 25, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Mardela Springs</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Harry Sinclair</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie V. Fithian</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-70-3841</b>		17. INFORMANT ADDRESS <b>(daughter) Main Street Mrs. Leah Ray, Mardela Springs, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Subendocardial myocardial Infarction</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>4/22/81</b> 19 to <b>4/28</b> 19, that (1) (we) last saw the deceased alive on <b>4/28/81</b> 19, and that (1) (my) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Clinton L. Roach M.D.</b>				22c. DATE SIGNED <b>4/29/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clinton L. Roach M.D.</b>				22e. ADDRESS <b>Locust &amp; Quincy St's Salisbury Wic. Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Gardens, Salisbury Wic. Maryland</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wic. Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>			
25a. DATE REC'D BY REGISTRAR <b>APR 30 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Patricia M. Berry</b>	



Wisconsin

Peninsula General Hospital

Bellevue



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3, 4, and 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ethel Frances Fitzgerald			2a DATE OF DEATH MONTH DAY YEAR April 2, 1981		2b HOUR 10:20 P <sub>M</sub>	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 2, 1914		
6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md.		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Coulbourn Drive		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Seamstress		
13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		
14 FATHER'S NAME FIRST MIDDLE LAST Sylvester C. Shockley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Butler				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 214-10-7162		17 INFORMANT (son) ADDRESS same as 13 Mr. Donald C. Fitzgerald, Salisbury		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung with Brain Metastasis 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) gave rise to immediate } cause (a), stating the } underlying cause last } (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from June, 1956 19, to 4-2-81 19, that (I) (we) last saw the deceased on 3-26-81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.						
22b SIGNATURE Earl L. Royer, M.D.		DEGREE		22c DATE SIGNED 4/7 /81		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 409 Camden Ave., Salisbury, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/5/81		23c NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		
23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland		24 FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.				
25a DATE REC'D. BY REGISTRAR APR 9 1981		25b REGISTRAR'S SIGNATURE R. J. Kelly				



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY M. Fleming</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 2, 1981</b>			2b. HOUR <b>6:30 P.M.</b>		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 4, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <b>Maryland Worcester</b>					13c. CITY OR TOWN <b>Pocomoke</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>203 6th Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Mann</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>170-10-6339</b>		17. INFORMANT ADDRESS <b>Wayne Fleming 205 The Parkway Ithaca, New York 14850</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AS. EX B</b> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED INJURY <input type="checkbox"/> NOT INJURY <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/3/81</b> to <b>4/2/81</b> that (I) (we) last saw the deceased alive on <b>4/2/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b> DEGREE						22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Scott S. Nelson</b>	
22e. ADDRESS <b>Pocomoke City, Md.</b>						22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Epis. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pocomoke Worcester Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Scott S. Nelson</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 6 1981</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

Item 18b G555 5/6/81 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 1 5 3 3

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Fannie B. Foley		2a. DATE OF DEATH MONTH DAY YEAR 4-15-81 2b. HOUR 11:50P <sub>M</sub>	
3 SEX F	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5-9-09	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE PA.		13b. COUNTY PHILA.	
13c. CITY OR TOWN PHILA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4533 HALE ST.		14. FATHER'S NAME WILLIAM COULBOURN BROWN	
15. MOTHER'S MAIDEN NAME ANNIE SUDDER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO 197-10-6598		17. INFORMANT ADDRESS MRS. ANNE B. DOLBY SALISBURY, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (D) 1991 Carcinoma Metastatic to Brain DUE TO, OR AS A CONSEQUENCE OF (b) Primary carcinoma melanoblastoma DUE TO, OR AS A CONSEQUENCE OF (c) known, biopsy of brain tissue revealed metastatic cancer.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Origin of cancer not	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION Feb 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy brain metastasis	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joseph C. Fitzgerald		22c. DATE SIGNED 4-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. FITZGERALD, M.D.		22e. ADDRESS CIVIC AVE, & RT. 50. SALISBURY, MD. 21801	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/18/81	
23c. NAME OF CEMETERY OR CREMATORY MANOKIN PRES. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.		25a. DATE REC'D. BY REGISTRAR APR 20 1981	
25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 3 4			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME				2a. DATE OF DEATH			
FIRST LAST				MONTH DAY YEAR HOUR			
Archie Ray FORD				APR 4 23 81 12 35 PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		OCT. 8, 1909		71	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Wicomico MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		RETIRED			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS			
MD. SOMERSET PRINCESS ANNE				H.F.D. 3 BOX 472C			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
ARCHIE T. FORD				MAUDE FORD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				219-36-6466		MRS MARY FORD PRINCESS ANNE, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>anoxia &amp; gastrointestinal bleeding</u>							
5715							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>3/11</u> , 19 <u>81</u> , to <u>4/23</u> , 19 <u>81</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>4/23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
M. Ben Homer MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/23/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		4/25/81		OLIVER T. BEAUCHAMP		PRINCESS ANNE, MD	
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LEVIN R. WILSON PRINCESS ANNE, MD.				APR 27 1981		M. Ben Homer	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 1 1 1 5 3 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alonzo William Foxwell</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 9 1981</b>					2b. HOUR <b>8<sup>15</sup> M</b>
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 11, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Salisbury, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Taxi Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alonzo W. Foxwell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lola Messick</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT (son) <b>Mr. Danny Lee Foxwell, Salisbury, Md.</b>		ADDRESS <b>420 Liberty St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>yes</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>congestive failure, arteriosclerotic heart disease</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (b) (this hospital) attended the deceased from <b>Oct 19 65</b> , to <b>April 9, 19 81</b> , that (b) (we) last saw the deceased alive on <b>April 9, 19 81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>John T. Bulkeley</b>		DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-10-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John T. Bulkeley, M.D.</b>		22e. ADDRESS <b>Salisbury, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/13/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wicomico, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Bulkeley</b>								

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San Antonio General Hospital

San Antonio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar in the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	1	5	3	6
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <u>Lillian</u> <u>Frederick</u>										2a. DATE OF DEATH MONTH DAY YEAR <u>April 4 29 81</u>				2b. HOUR <u>10<sup>15</sup> PM</u>		
3. SEX <u>Female</u>			4. RACE <u>Cau.</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7-7-01</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.							
10. CITY OR TOWN OF DEATH <u>Salisbury</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
13a. STATE <u>Del.</u>			13b. COUNTY <u>Sussex</u>		13c. CITY OR TOWN <u>Laurel</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Box 270</u>						
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Anthony</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Bessie Bartlett</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b. SOCIAL SECURITY NO. <u>209-40-3605</u>			17. INFORMANT ADDRESS <u>Gilbert M. Frederick</u>					<u>Laurel, Del.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (a) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>80</u> , to <u>4-29</u> , 19 <u>81</u> , that (b) (we) lost <u>4-29</u> <u>81</u> , and that (c) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)																
22b. SIGNATURE <u>Roger Merrill</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4-29-81</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roger Merrill</u>				22e. ADDRESS <u>KAY AVE</u> <u>SALISBURY MARYLAND 21801</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>5-2-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cem.</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Centreville O.A. Md.</u>						
24. FUNERAL DIRECTOR NAME <u>John E. Boulaus</u>				ADDRESS <u>Greensboro Md.</u>				25. DAY RECEIVED BY REGISTRAR <u>MAY 4 1981</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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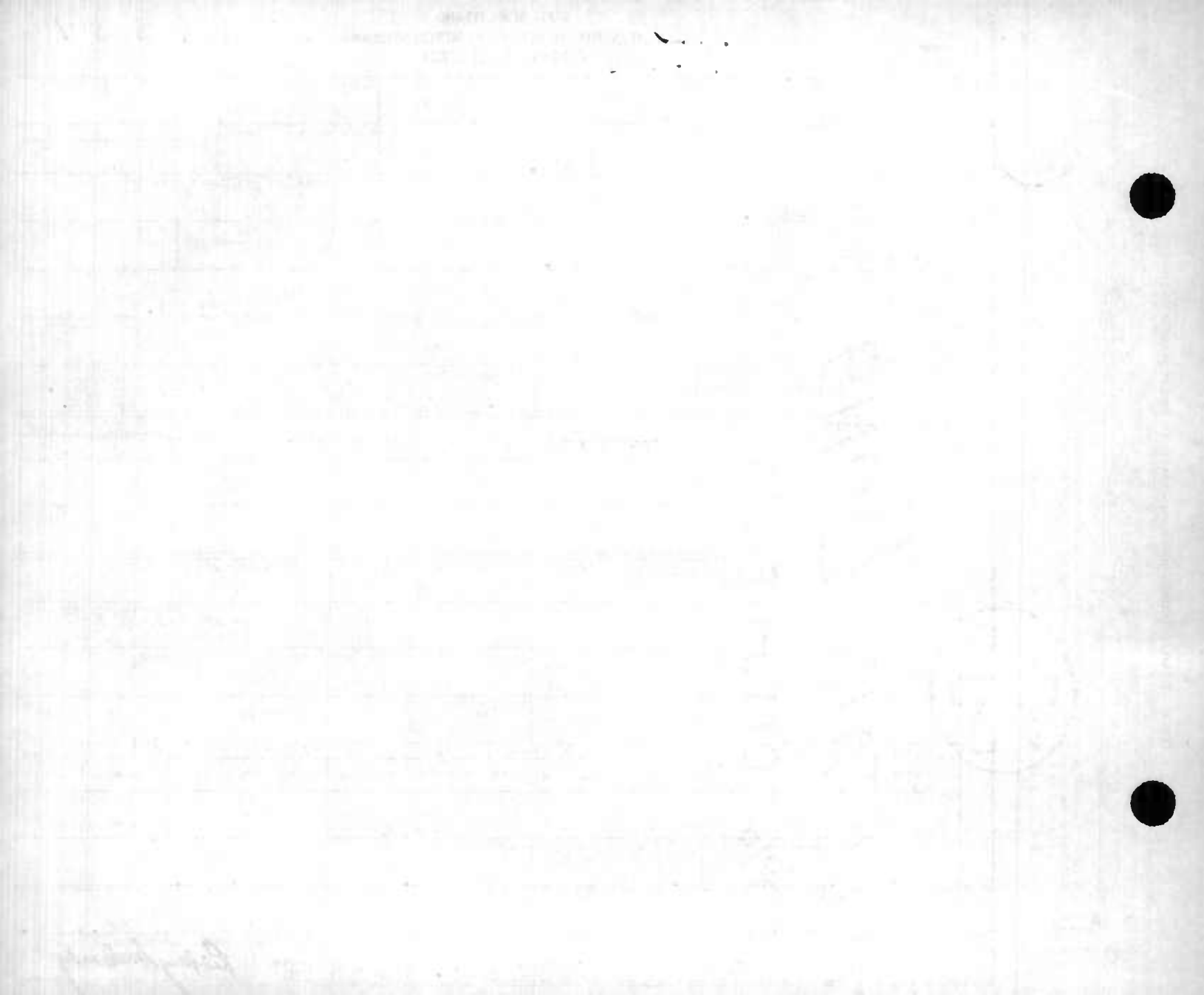
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-2201.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8111537										
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Mae Gannon					April 20, 1981					M
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 2, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsville, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Walston Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stanford Asbury Mitchell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Mary Bodley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-14-3005		17. INFORMANT ADDRESS Mr. Gerald Rogers, 105 North Bay St. Snow Hill, Md.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pericardial Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-27</u> , 19 <u>81</u> , to <u>4-20</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Wilber R. Ellis, Jr.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/27/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilber R. Ellis, Jr.				22e. ADDRESS Kay Ave., Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/81		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park, Salisbury, Wic., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR APR 29 1981		25b. REGISTRAR'S SIGNATURE <u>R. H. H. H.</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

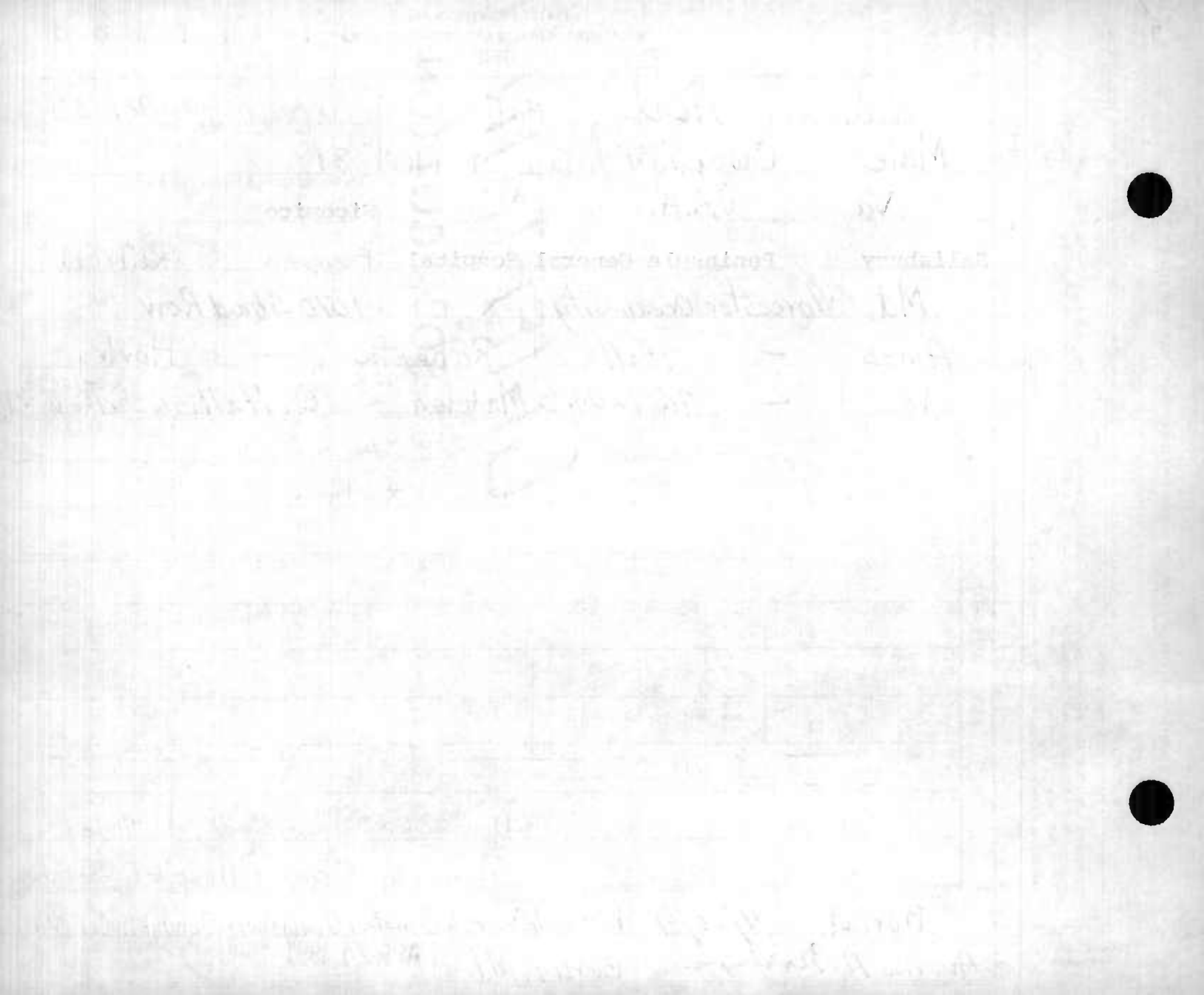
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 1 5 3 8				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>William Asa Hall</u>					2a. DATE OF DEATH MONTH <u>April</u> DAY <u>14</u> YEAR <u>1981</u> 2b. HOUR <u>5<sup>40</sup></u> M				
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>Jan</u> DAY <u>7</u> YEAR <u>1900</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.			
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Engineer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
13a. STATE <u>Md.</u> 13b. COUNTY <u>Worcester</u> 13c. CITY OR TOWN <u>Ocean City</u>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>1510 Shad Row</u>		
14. FATHER'S NAME FIRST <u>Amos</u> MIDDLE <u>-</u> LAST <u>Hall</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Roberta</u> MIDDLE <u>-</u> LAST <u>Hurley</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>716-12-2963</u>		17. INFORMANT <u>Madelon C. Hall</u> ADDRESS <u>1510 Shad Row Ocean City, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Epidermoid Carcinoma</u> <u>1991</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>with lung, brain metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> 19 <u>81</u> , to <u>9/14</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/14/81</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph N. Grasso</u>					DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4/14/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph N. Grasso</u>					22e. ADDRESS <u>Peninsula General Hospital Salisbury</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>4/20/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kimmels Church Cemetery</u>		23d. LOCATION (CITY OR TOWN) <u>Schuylkill Co. Pa.</u> COUNTY <u></u> STATE <u></u>		
24. FUNERAL DIRECTOR NAME <u>Anna A. Burby</u>					ADDRESS <u>Berlin, Md.</u>		25. DATE RECD. BY REGISTRAR <u>APR 21 1981</u> REGISTRAR'S SIGNATURE <u></u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leonard F. HAMPTON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4-22-81</b>			2b. HOUR <b>4:15P</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-26-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS <b>8 26</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Salisbury Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Brakeman B&amp;O Railroad</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Delmar</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12 W. State St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ulysses Grant Hampton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Thompson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>705-05-5593</b>		17. INFORMANT ADDRESS <b>Marion Pinkoski Delmar, Del.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastases</b> <b>1950</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1972</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/22/81</b> to <b>4/22/81</b> , that (I) (we) lost <b>11/10/81</b> above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Earl M. Beardsley</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4/23/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. EARL M. BEARDSLEY</b>				22e. ADDRESS <b>CIVIC AVE, RT. 50, SALISBURY, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-25-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cem. Delmar Sussex Del.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>William M. Short</b>				25. DATE REC'D BY REGISTRAR <b>APR 27 1981</b>				25b. REGISTRAR'S SIGNATURE <i>W. M. Short</i>	
24. FUNERAL HOME <b>Marvel-Short Funeral Home Delmar, De.</b>									

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*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR MIN.
Firman P. Hastings						APRIL 8, 1981			1:26 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Jan. 31, 1912		69 YRS.		2 7	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U. S. A.				Wicomico MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				Ret. Brick Mason			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			Maryland		Wicomico		Hebron		13e. STREET ADDRESS
									103 Howard St.
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Gordon Hastings					Edyth Ruark Hastings				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			212-12-3703		Zeta K. Hastings Hebron, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerotic Cardiac Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINS</u> <u>HRS</u> <u>YRS</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from <u>4/6</u> , 19 <u>81</u> , to <u>4/8</u> , 19 <u>81</u> , that (we) lost <u>4/8</u> above, (live) (die) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>Dr. M. Wood</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/8/81</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. M. Wood</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4-11-81		Mardela Cem.		Mardela Wicomico Md.		
24. FUNERAL DIRECTOR NAME <u>William M. Short</u> ADDRESS <u>Marvel-Short Funeral Home Delmar, De.</u>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
					APR 14 1981				

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Emilia General Hospital



Handwritten signature

1981

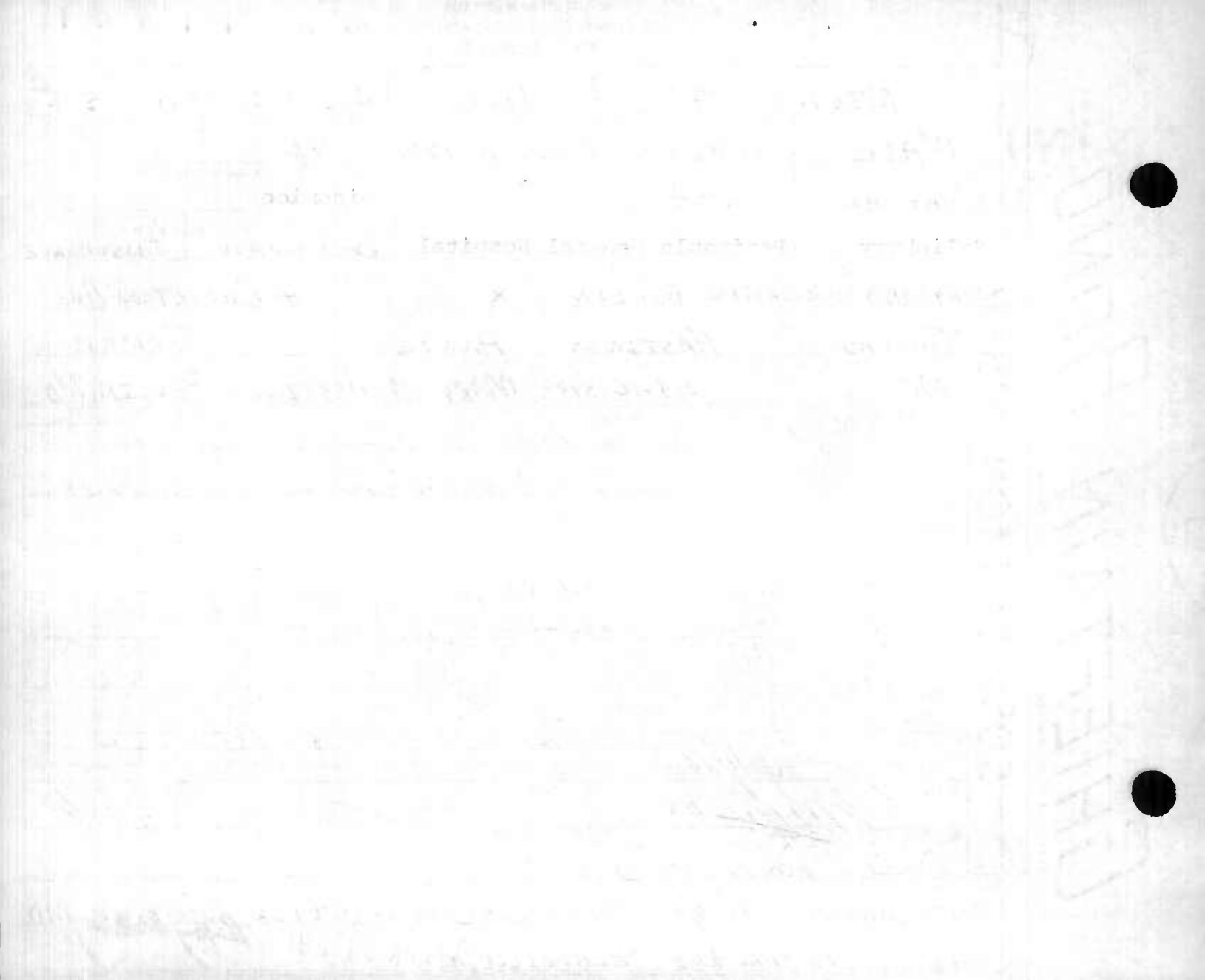
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>MILTON T. HASTINGS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 20, 1981</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 30, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		2b. HOUR <b>8<sup>25</sup> A.M.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>WORCESTER</b>		13c. CITY OR TOWN <b>BERLIN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4 POWELLTON AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS HASTINGS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE TURNER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-10-8988</b>		17. INFORMANT ADDRESS <b>MARV M. HASTINGS, BERLIN, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Artery Dissep</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>9-96-12-1 Artherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>14 known</b> <b>16 known</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Myocardial Infarction</b> <b>312981</b>										
19a. DATE OF OPERATION <b>3/29/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aneurysm</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/25/81</b> 19 to <b>4/20/81</b> 19 that (I) (we) last saw the deceased alive on <b>3/25/81</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) see the body after death.										
22b. SIGNATURE <b>David Phoebe MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/20/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <b>Salisbury MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>			23b. DATE <b>4/23/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BERLIN, WORCESTER, MD</b>			
24. FUNERAL DIRECTOR NAME <b>HASTINGS FUNERAL HOME</b>			ADDRESS <b>SELBYVILLE, DE</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE			5. DATE OF BIRTH		
ALBIN			Male			White			Dec. 11, 1895		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			USA						WICOMICO MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
SALISBURY			SALISBURY NURSING HOME			Pharmacist			Drug Store		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Wicomico			Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Joseph Kirwin Hayman			Abbie Rose Johnson			Yes			WW I 220-32-7883		
17. INFORMANT (son)			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac dysfunction</i> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>		
Mr. Charles Hayman			21 Silver Run Lane, Salisbury, Md.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/31</i> 19 <i>80</i> to <i>4/1</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>3/31</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<i>Earl M. Beardsley</i>			M.D.						<i>4/1/81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
EARL M. BEARDSLEY, M.D.			U.S. 50-CIVIC AVE., SALISBURY, MD. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/3/81			Wicomico Mem. Park			Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
HOLLOWAY FUNERAL HOME, Salisbury, Md.			APR 6 1981			<i>Earl M. Beardsley</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11543	
1. DECEASED NAME (TYPE OR PRINT) William C. Hearn, Sr.						2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE KNOWN OF DEATH	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/22/1918		6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee			12b. KIND OF BUSINESS OR INDUSTRY Nylon Plant	
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 418 Priscilla Street		
14. FATHER'S NAME FIRST MIDDLE LAST John Hearn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Calloway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 222-09-5254		17. INFORMANT ADDRESS Mrs. Minna C. Hearn (wife) same as					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest 8/120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7:25 PM 4-1-81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto struck by truck.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection, Rt. 13 & Church St.,		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Salisbury, Wic. Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/4/81		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR APR 06 1981		25b. REGISTRAR'S SIGNATURE <i>Earl L. Royer</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

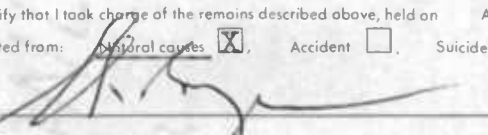

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 4 4			
FOR 1- STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) ALICE Marie HEARNE				2a. DATE OF DEATH MONTH DAY YEAR 4-10-81		2b. HOUR 22 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 15, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10 CITY OR TOWN OF DEATH SALISBURY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury	
14 FATHER'S NAME FIRST MIDDLE LAST John Madison Bloxom				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Osha Bundick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-26-5432		17. INFORMANT ADDRESS same as 13 Mr. Harris A. Hearne (husband)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4409 Congestive Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. C. Mitchell M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10 April 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Mitchell, M.D.				22e. ADDRESS Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/12/81		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland	
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR APR 13 1981		25b. REGISTRAR'S SIGNATURE [Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11545			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH M. HEMPHILL</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4-2-81</b>		2b. HOUR <b>8:30A</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4-2-81</b>		2d. HOUR <b>11</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-20-16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>				9d. BALTIMORE CITY OR COUNTY OF DEATH <b>MD.</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>						13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Bishopville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 46</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence M. Gray</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Merritt</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>221-20-1883</b>		17. INFORMANT ADDRESS <b>Harry Hemphill Bishopville, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> (c) <b>Diabetes Mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>						ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>April 15, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bishopville Worcester MD</b>			
24. FUNERAL DIRECTOR NAME <b>Watson &amp; Whaley, Selbyville, De.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 07 1981</b>		25b. 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 1 1 5 4 6					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
Hilda M. HOLDER					April 30, 1981					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR		
Female		White		Sept. 20 1920		60 YRS.		11:10 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U. S. A.				Wicomico MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Deer's Head Center				Garment Factory Worker				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Caroline		Federalsburg,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Milton Magers					Grace Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
n/a			213-05-4696		Mrs. Helen Lewis Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>congestive heart failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic c.v.d.</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CVA</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
<u>Edward P. Ritchings, M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			4/30/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Edward P. Ritchings, M.D.					Deer's Head Center; Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			May 3, 1981		Hillcrest		Federalsburg Car Md.			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Edna M. Williams Federalsburg</u>					MAY 6 1981					







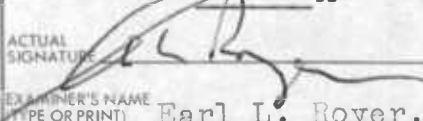
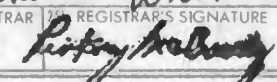
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		8 1 1 5 4 7									
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM S. HORSEY</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4-4-81				7b. HOUR A M	
3. SEX Male	4. RACE AA	5. DATE OF BIRTH MONTH DAY YEAR 6 6 06	6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 4-4-81 19				2d. HOUR 8:30A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Hebron		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 302 Chestnut St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.						13b. COUNTY Wicomico		13c. CITY OR TOWN Hebron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 302 Chestnut St.											
14. FATHER'S NAME FIRST MIDDLE LAST GRANVILLE HORSEY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GALE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-34-8578		17. INFORMANT ADDRESS Eunice Horsey 302 Chestnut St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 4-6-81			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-9-81		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Garden				23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wico. Md.			
24. FUNERAL DIRECTOR NAME Clinton Stewart, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR APR 10 1981				25b. REGISTRAR'S SIGNATURE 			

APR 1 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 4 8			
FOR 1- STATE REGISTRAR				CERTIFICATE OF DEATH			
1 DECEASED NAME				2a DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
HETTIE B. HUDSON				April 30, 1981			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE	
FEMALE		WHITE		MONTH DAY YEAR		82 YRS.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				Wicomico MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		HOUSEWIFE		HOME	
13a STATE				13b CITY OR TOWN		13c STREET ADDRESS	
DELAWARE				SELBYVILLE		CHURCH STREET	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
JAMES S. BEAUCHAMP				MARTHA HASTINGS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO.		17. INFORMANT	
NO				221-50-1459		ADDRESS	
				JOHN J. HUDSON, SELBYVILLE, DE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) <i>Acute left ventricular Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Non-specific pneumonia with cavity formation</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral thrombosis with partial hemiplegia</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cerebral thrombosis with partial hemiplegia</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED			
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
AT WORK							
22a. I certify that (I) (this hospital) attended the deceased from <i>2-24-1981</i> to <i>4-30-1981</i> , that (I) <del>was</del> lost saw the deceased alive on <i>4-30-1981</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <del>did not</del> view the body after death.							
22b SIGNATURE				DEGREE		22c DATE SIGNED	
<i>James H. Clifford MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>4/30/81</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
JAMES H. CLIFFORD MD				#12 MEDICAL CENTER SALISBURY MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
BURIAL		<i>5/3/81</i>		ODD FELLOWS		BISHOPVILLE, WORE, MD	
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
<i>Charles W. Hastings, Selbyville, Del.</i>				<i>MAY 6 - 1981</i>		<i>Patricia Roberts</i>	

Wilmington

Peninsula Federal Hospital

Wilmington

CHURCH STREET

Wilmington

Wilmington

Wilmington

Wilmington

Wilmington

Wilmington

Wilmington

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8111549	
1 - FOR STATE REGISTRAR			REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>WILLIAM J HUTT</b>			2a DATE OF DEATH MONTH DAY YEAR <b>April 19 1981</b>		2b HOUR <b>8:10 PM</b>	
3 SEX <b>MALE</b>	4 RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10 CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MD</b>			13b COUNTY <b>WICOMICO</b>	13c CITY OR TOWN <b>FRUITLAND</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WM HUTT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLY BIVENS</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>213-22-6199</b>		17 INFORMANT ADDRESS <b>EVELYN HUTT 1340 SO DIVISION ST</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the lung with Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Obstructive Lung Disease</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>4/19/81</b> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>Benito S. Chan MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>4/19/81</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENITO S. CHAN</b>		22e ADDRESS <b>544-D Riverside Drive</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>4-25-81</b>		23c NAME OF CEMETERY OR CREMATORY <b>West Rest of the Park Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Somerset</b>
24 FUNERAL DIRECTOR NAME <b>West Funeral Home Sales</b>		24a DATE REC'D. BY REGISTRAR		24b REGISTRAR'S SIGNATURE <b>Jeffrey McBrady</b>		24c DATE <b>APR 23 1981</b>

BP \_\_\_\_\_



Wichita

Wichita General Hospital

Wichita

Wichita General Hospital





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 5 0	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Frank JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 26, 1981</b>		2b. HOUR <b>4:40p M</b>
3 SEX <b>Male</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1906</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS MONTHS DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. CITY OR TOWN <b>Cecil</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>84 Waters Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Brinkly Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Johnson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-14-0104</b>		17. INFORMANT ADDRESS <b>Box 271 Warwick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292</b> <i>antagonistic cardiovascular</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. P. Ritchings, MD</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/26/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. P. RITCHINGS, M. D.</b>		22e. ADDRESS <b>Deer's Head Center, Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/2/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bohemia Manor</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bohemia Maryland</b>	
24. FUNERAL DIRECTOR NAME <i>Ernest M. Congo</i> <b>Ernest M. Congo</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 1 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Robert M. ...</i>	

RECEIVED  
JAN 11 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 5 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
MARGARET EMMA JOHNSON				APRIL 4, 1981				7 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		FEB. 3, 1889		92 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U. S. A.				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				CASHIER		Pen. Gen. Hsp.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Crooked Oak Lane - Rt. 5	
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
ALISON JOHNSON				MARGARET HILGEMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				214-32-0609		MARGARET LINDEN, Salisbury, Md.		1016 Loxcroft Dr. Salisbury, Md. 21801			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Staphylococcal Septicemia										3 days	
6826 DUE TO, OR AS A CONSEQUENCE OF, (b) Cellulitis of right leg.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Congestive Heart Failure.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 3.31.19.81, to 4.4.19.81, that (we) lost the deceased alive on 4.3.19.81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) did (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Roger Merrill				MD				4.4.81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ROGER C. MERRILL MD				KAY AVE SALISBURY MD 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				4/7/1981		PARSONS Cem.		Salisbury, Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arlt Baker-Bounds				Salisbury, Md.				APR 9 1981			

London

London (Central)

London

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8111552			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>MILTON R JOHNSON</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>APRIL 30 1981</u>		2b. HOUR <u>10 30 A.M.</u>	
3 SEX <u>MALE</u>		4 RACE <u>NEGRO</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5 15 15</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>EXMORE, VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.	
10 CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>BERLIN</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>MILTON JOHNSON</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Laura Williams</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-16-8297</u>		17. INFORMANT ADDRESS <u>Rt. 2 Box 91</u> <u>BERLIN, MARYLAND</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung carcinoma</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>April 2, 1981</u> to <u>April 3, 1981</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>4/30</u> 19 <u>81</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph M. Grasso</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/30/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph M. Grasso</u>				22e. ADDRESS <u>1300 S. Division St</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>5/8/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BERLIN WORCESTER MARYLAND</u>	
24 FUNERAL DIRECTOR NAME <u>JOLEY MEMORIAL CHAPEL</u>				25. DATE RECORD REGISTERED <u>Rt. #2 Jersey Road</u> ADDRESS <u>SALISBURY, MD</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eddie LEE Jones</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 14 1981</b>		2b. HOUR <b>3<sup>20</sup> AM</b>	
3 SEX <b>Male</b>	4 RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 25 1936</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>veg. CANNERY</b>
13a. STATE <b>Del.</b>	13b. COUNTY <b>SUSSEX</b>	13c. CITY OR TOWN <b>MILTON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>RFD</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY Jones</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA Ward</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>2A-34-5155</b>		17 INFORMANT NAME ADDRESS <b>Garnie M. Jones Lake Manor Bldg 12 Apt. 3 Orlando, Fla.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>alcohol withdrawal syndrome, alcoholism</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 weeks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>alcohol withdrawal syndrome, alcoholism</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 2</b> , 19 <b>81</b> , to <b>Apr 14</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Apr 13</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William J Nagel MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4-14-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J NAGEL, MD</b>		22e. ADDRESS <b>Peninsula Gen Hosp. Salisbury, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>Apr. 21 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Full County</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Md</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 27 1981</b>		23f. REGISTRAR'S SIGNATURE <b>Patricia McHenry</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE Branock LAST Langelier					2a. DATE OF DEATH MONTH DAY YEAR April 30, 1981			2b. HOUR 2:30 P.M.		
1. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-14-1915		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Md.					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Airey Branock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Husbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS CARL Langelier, Same as 13c						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 4-24, 1981, to 4-30, 1981, that (1) (we) last saw the deceased alive on 4-29, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.										
22b. SIGNATURE D. W. Todd Jr. M.D.						DEGREE M.D.		22c. DATE SIGNED 4-30-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. W. Todd Jr. M.D.						22e. ADDRESS Medical Ctr West Salisbury Md				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 5/2/1981		23c. NAME OF CEMETERY OR CREMATORY Parsons Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md.			
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds						ADDRESS Salisbury Md.		25a. DATE REC'D. BY REGISTRAR MAY 5 1981		
						25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION



1911

MINNESOTA GENERAL HOSPITAL

ST. PAUL, MINN.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PART 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11555	
1. DECEASED NAME (TYPE OR PRINT) <b>Derek Thomas Layfield</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> MONTH DAY YEAR <b>4 29 19 81</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1981</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>24</b>		IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 30 19 81</b>	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County MD</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Delmar</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>114 E. East St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Thomas Layfield</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>June Elaine Dawson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Samuel Thomas Layfield Delmar, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b> 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Hormez R. Guard</b>						TITLE (SPECIFY) <b>M.D. Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>5/1/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>						ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Delmar Sussex Del.</b>			
24. FUNERAL DIRECTOR NAME <b>William M. Short Jr.</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>L. J. K. K. K.</b>			
Funeral Home <b>Marvel-Short Funeral Home Delmar, Del.</b>						MAY 6 - 1981					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Luther W. LITTLETON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 2, 1981</b>		2b. HOUR <b>10A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Weigh Master</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Wicomico</b> 13c. CITY OR TOWN <b>Pittsville</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>Rt. 1 Box 219</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Littleton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Effie Bradford</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>212-16-1273</b>		17. INFORMANT ADDRESS <b>Elsie Littleton Pittsville, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, Carles</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial infarct</b> (c) <b>Chronic Coronary</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>None</b> <b>4h</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Chronic kidney disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/2/81</b> to <b>4/2/81</b> , that (I) (we) lost <b>4/2/81</b> saw the deceased alive on <b>4/2/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. GARY GREEN MD</b>		DEGREE		22c. DATE SIGNED <b>4/2/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>QUINCY E. LOCUST STS. SALISBURY, MD 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APRIL 5, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PITTSVILLE</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>PITTSVILLE WICOMICO MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>WATSON &amp; WHALEY SELBYVILLE, DE</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 07 1981</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Indicate the General Location

of the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 1 1 1 5 5 7				
1. DECEASED NAME (TYPE OR PRINT) <b>Robert C. Malone</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1981</b>					2b. HOUR <b>12:16 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.								
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Poultryman</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Wicomico</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Snow Hill, Md. Rt. 2 Box 78 D.</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Malone</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jenny Martin</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-32-2464</b>		17. INFORMANT ADDRESS <b>Rt. 2 Box 78 D Mrs. Marion Malone, Snow Hill, Md.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemic Shock</b> <b>7140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pell's Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Advanced Rheumatoid Arthritis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Leg Ulcers, Chronic Obstructive Pulmonary Disease</b>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1981</b> to <b>April 11, 1981</b> , that (I) (we) saw the deceased alive on <b>4/11</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)														
22b. SIGNATURE <b>Robert M. Soldado</b>					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>		23b. DATE <b>4/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memorial Park Salisbury Wicomico</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>								
24. FUNERAL DIRECTOR NAME <b>James L. Hennessey</b>					ADDRESS <b>Phenix House, Ind.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 16 1981</b>							

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*[Handwritten signature]*

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1. STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Roscoe F. Martin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 10 1981</b>		2b. HOUR a.m. <b>9:10<sub>M</sub></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01/11/1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <b>MD. WICOMICO FRUITLAND</b>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>CENTER ST.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN H. MARTIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADELL WILLEY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-03-5406</b>		17. INFORMANT ADDRESS <b>EDGAR MARTIN FRUITLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bronchogenic carcinoma with metastases to esophagus with radiation status post left pneumonectomy</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 02</b> , 19 <b>81</b> , to <b>April 10</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>April 10</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>L. V. Maldve</i>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>04/10/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. V. Maldve, M.D., Chief Physician</b>		22e. ADDRESS <b>Deer's Head Center, Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/13/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALISBURY, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b>			
24. FUNERAL DIRECTOR NAME <b>Wilson - Funeral Home</b>		ADDRESS <b>Salisbury, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony H. Brady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MORTLE J. MELVIN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 01, 1981</b>					2b. HOUR <b>7:10a M</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 2 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO, MD.</b>				
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DEER'S HEAD CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Baker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		
13a. STATE <b>Virginia</b>					13b. CITY OR TOWN <b>Accomack</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>108 Willow Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Tyndall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>165-10-5883-A</b>		17. INFORMANT ADDRESS <b>Mittie Ring Daughter</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic disease &amp; Cardiac arrhythmias</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEB. 09</b> , 19 <b>81</b> , to <b>Apr. 01</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Apr. 01</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>M. Shrestha</b>					DEGREE		22c. DATE SIGNED <b>04/01/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Maheswari Shrestha, M.D.</b>					22e. ADDRESS <b>P.O. Box 2018, Salisbury, Md. 21801</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4-1-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory Lewes</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Shuxsex De</b>				
24. FUNERAL DIRECTOR NAME <b>Peter Whaley</b>				ADDRESS <b>9490 Selbyville, De.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 7 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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1. The first part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900. The letter is addressed to the Secretary of the Department of the Army, and is signed by the Secretary of the Department of the Interior.

2. The second part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Navy, dated 1900. The letter is addressed to the Secretary of the Department of the Navy, and is signed by the Secretary of the Department of the Interior.

3. The third part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the War, dated 1900. The letter is addressed to the Secretary of the Department of the War, and is signed by the Secretary of the Department of the Interior.

4. The fourth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the State, dated 1900. The letter is addressed to the Secretary of the Department of the State, and is signed by the Secretary of the Department of the Interior.

5. The fifth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Treasury, dated 1900. The letter is addressed to the Secretary of the Department of the Treasury, and is signed by the Secretary of the Department of the Interior.

6. The sixth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Education, dated 1900. The letter is addressed to the Secretary of the Department of the Education, and is signed by the Secretary of the Department of the Interior.

7. The seventh part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Agriculture, dated 1900. The letter is addressed to the Secretary of the Department of the Agriculture, and is signed by the Secretary of the Department of the Interior.

8. The eighth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Commerce, dated 1900. The letter is addressed to the Secretary of the Department of the Commerce, and is signed by the Secretary of the Department of the Interior.

9. The ninth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Labor, dated 1900. The letter is addressed to the Secretary of the Department of the Labor, and is signed by the Secretary of the Department of the Interior.

10. The tenth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Justice, dated 1900. The letter is addressed to the Secretary of the Department of the Justice, and is signed by the Secretary of the Department of the Interior.

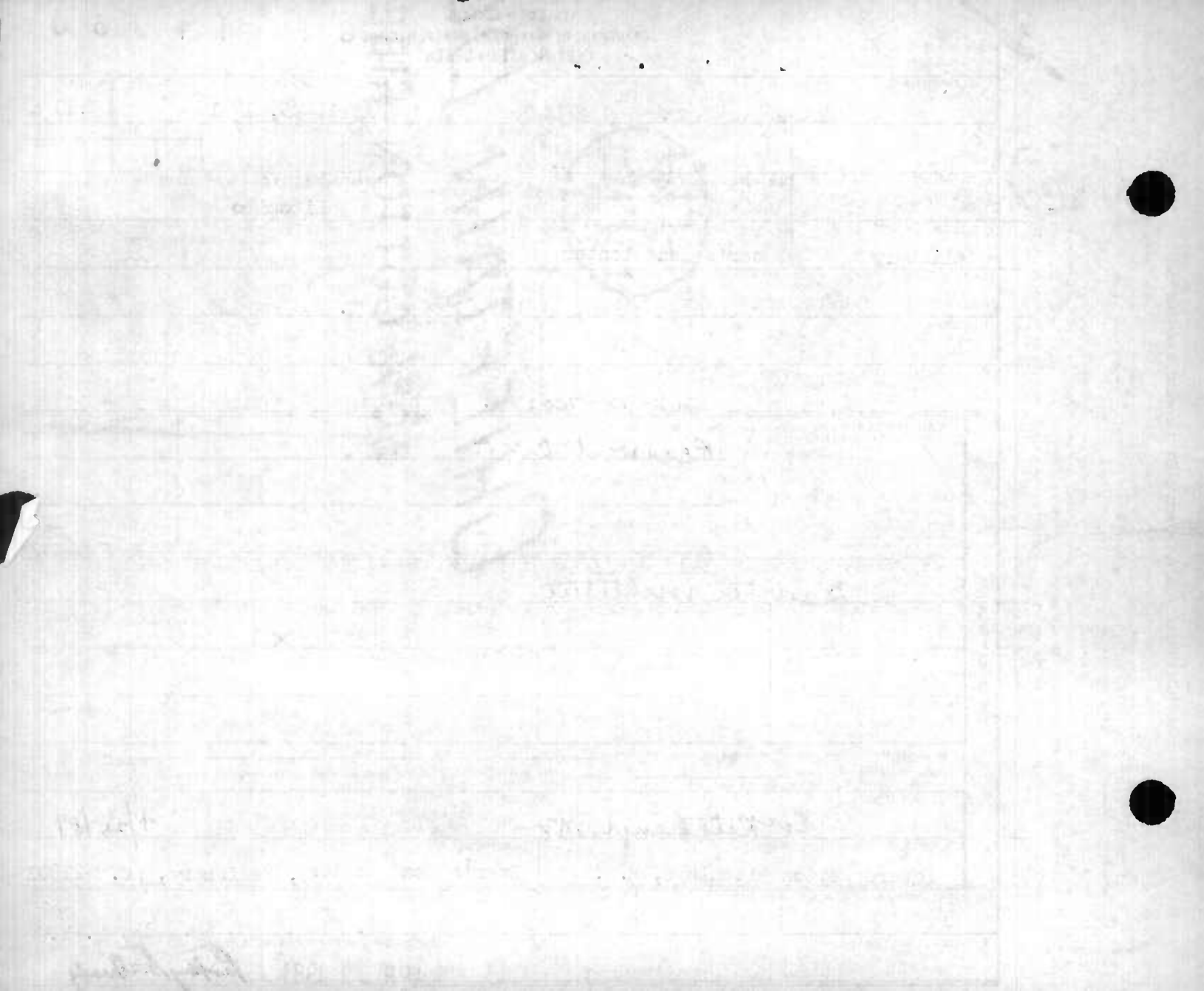
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 6 0			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Catherine Florence MILLER				2a. DATE OF DEATH MONTH DAY YEAR April 25, 1981				2b. HOUR 3:20 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Westover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 169			
14. FATHER'S NAME FIRST MIDDLE LAST William Nicholas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Pegenering							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 266-98-7002		17. INFORMANT Mrs. Clara Hudson (daughter) same as 13				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent CVA</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Sickle cell trait</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward Peyton Ritchings, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/25/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Peyton Ritchings, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/29/81		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Memorial Cen. Pine Lawn, Suffolk, N. Y.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 29 1981					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Minnie		--				OLSON		APRIL 18, 1981								2 <sup>10</sup> M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		IF UNDER 24 HRS		IF UNDER 24 HRS			
Female		White		Feb. 23, 1897		84		YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Berlin, Md.		USA				Wicomico										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General Hospital		Seamstress													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		426 E. Church Street									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
(unknown)						Cora		M.		Coffen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (grand-daughter)		ADDRESS											
NO		214-10-6484A		Mrs. Charlene Burns, Mitchellville, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1629		carcinoma of lungs															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
congestive heart failure, arteriosclerotic heart disease																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (1) this hospital attended the deceased from Jan 29, 1981, to April 18, 1981, that (1) (we) lost saw the deceased alive on Feb 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (we) (did not) view the body after death.		22b. SIGNATURE Rodney A Wernich		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
RODNEY A WERNICH		KAY AVE. SALISBURY Md. 21801															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		4/22/81		Wicomico Memorial		Park Salisbury, Md.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. BY REGISTRAR													
HOLLOWAY FUNERAL HOME, Salisbury, Md.		APR 21 1981															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8111562	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE H. PARKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1981</b>		2b. HOUR <b>6:25 a.m.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 30, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO, MD.</b>	
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Dor. Fishing Creek</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Hansel Parks</b>			15. MOTHER'S MAIDEN NAME MIDDLE <b>Viola Phillips</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>T. Hansel Parks, Fishing Creek, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Brain damage</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiac arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary heart disease &amp; Myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Apr. 03, 1981</b> to <b>Apr. 24, 1981</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Apr. 24, 1981</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Maheswari Shrestha</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>04/24/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Maheswari Shrestha, M.D.</b>		22e. ADDRESS <b>P.O. Box 2018, Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 26, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem. East Dor. Md.</b>	
24. FUNERAL DIRECTOR <b>Thomas Funeral Home, Cambridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR 25b. RECEIVED BY REGISTRAR <b>APR 28 1981</b> <b>P. J. H. H. H.</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

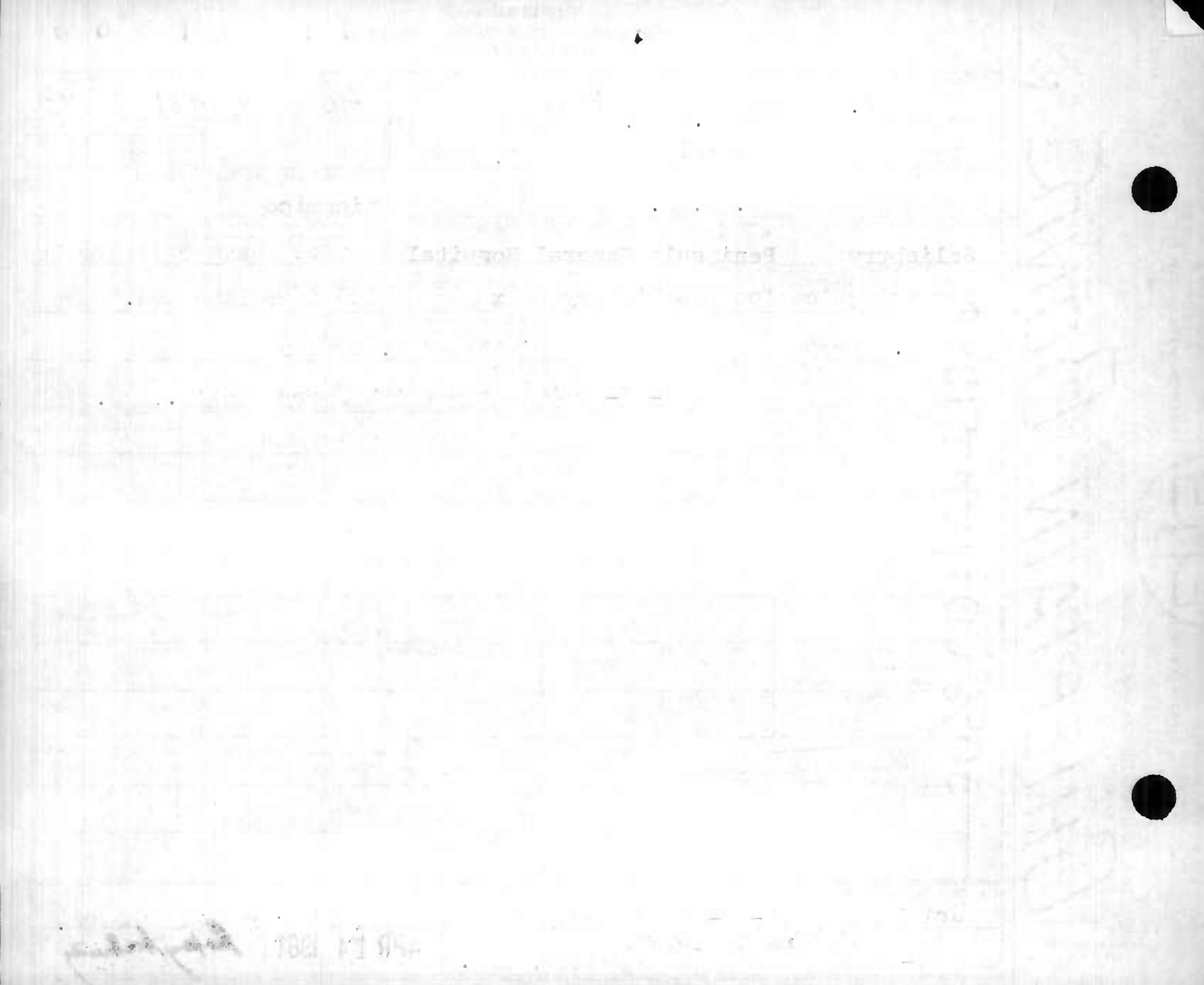
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 6 3			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				20. DATE OF DEATH			
J. Wayne Parry				April 7, 1981			
3. SEX		4. RACE		5. DATE OF BIRTH		2b. HOUR	
Male		White		May 17, 1947		7:28 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Maryland		U. S. A.		33		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital		Wicomico		Service Manager Electrolux	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland Wicomico Salisbury				13e. STREET ADDRESS			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
John O. Parry				Mildred L. Trader			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes				219-46-4934		Betty Leigh Parry Salis., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest and</u>							
1869 DUE TO, OR AS A CONSEQUENCE OF (b) <u>complications related to carcinoma</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4. Testes and its treatment</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>4/7</u> , 19 <u>81</u> , to <u>4/7</u> , 19 <u>81</u> , that (I) <u>we</u> lost <u>saw the deceased alive on</u> <u>4/7</u> , 19 <u>81</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>				MD		4/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		4-10-81		Springhill Memory		Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR NAME				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William M. Short				APR 14 1981		<u>[Signature]</u>	
Marvel-Short Funeral Home Delmar, Del.							

BP

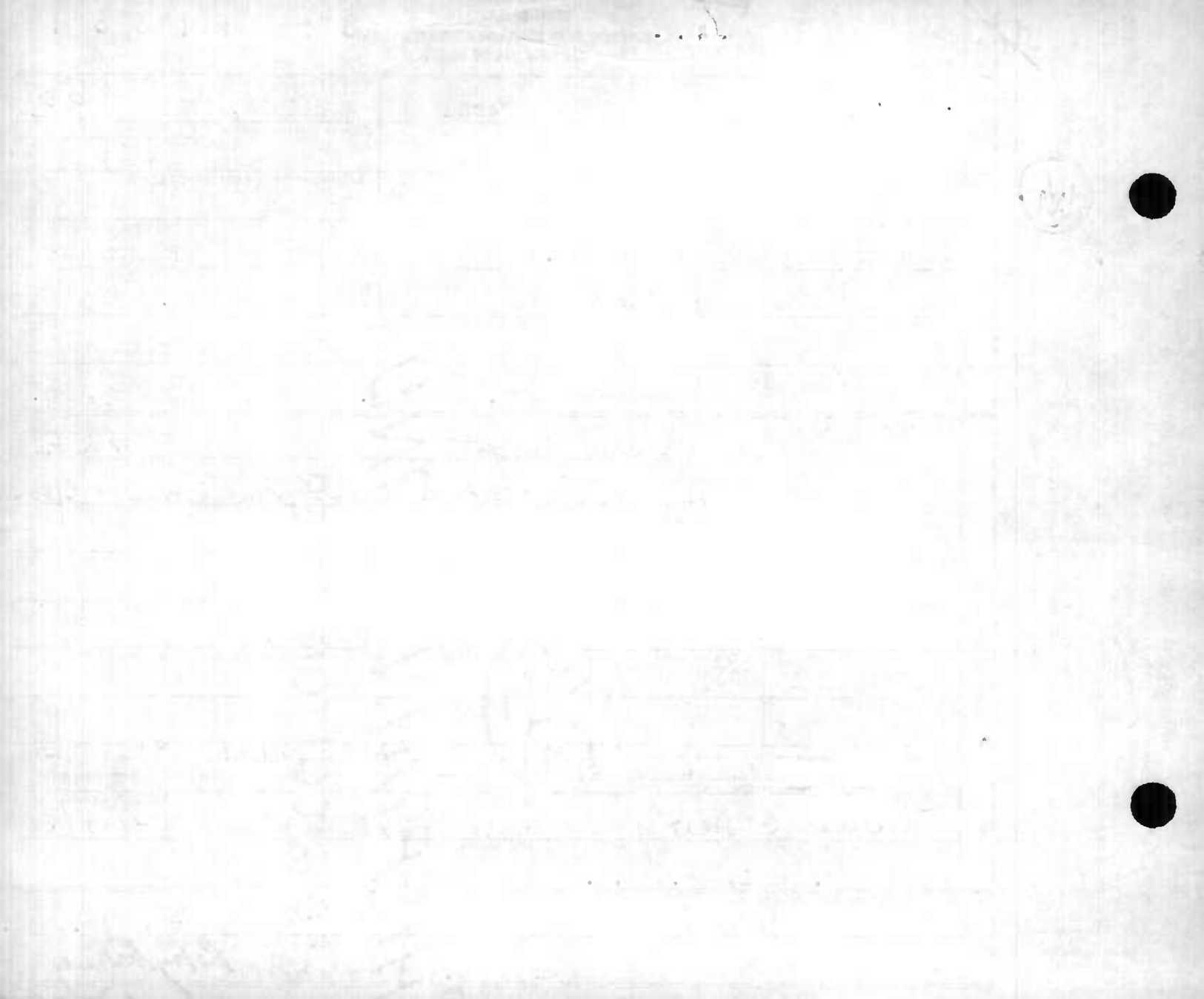


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edith Dashiell Perdue				2a. DATE OF DEATH MONTH DAY YEAR April 14, 1981			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 13, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 110 Carolyn Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Chicken Grower	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac West				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Ellen Griffin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-05-7533		17. INFORMANT (son) 2904 Ocean City Road Mr. Lewis W. Perdue, Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4/14/81 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive + Atherosclerotic Heart Disease</u> 4 years DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Jan 1970 to April 14, 1981, that (I) (we) last saw the deceased alive on March 10, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas C. Hill, Jr.				DEGREE M.D.		22c. DATE SIGNED 4/17/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. Hill, Jr., M.D.				22e. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/17/81		23c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery Parsonsbury, Wic., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR APR 21 1981		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director or the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16-50M 1/81  
(VRS 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
Rita E. PERRY		APRIL 27, 1981		9 <sup>30</sup> A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	60 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Canada	U. S. A.		Wicomico MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		Housewife		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Wicomico	Salisbury	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Salis. Mobile Home Park	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
N/A		N/A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		380-12-0425		Ernest W. Perry Salisbury, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
3-19-81		Carcinoma lung		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-9-81 to 4-27-81, that (I) (we) last saw the deceased alive on 4-27-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
E. KENT CARNEY M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4-27-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
E. KENT CARNEY M.D.		MEDICAL CENTER, SALISBURY, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		4-28-81		Delmarva Crematory Lewes, Delaware	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. STATE	
William M. Short		APR 30 1981		DE	
Marvel-Short Funeral Home Delmar, De.					

Michigan

General Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

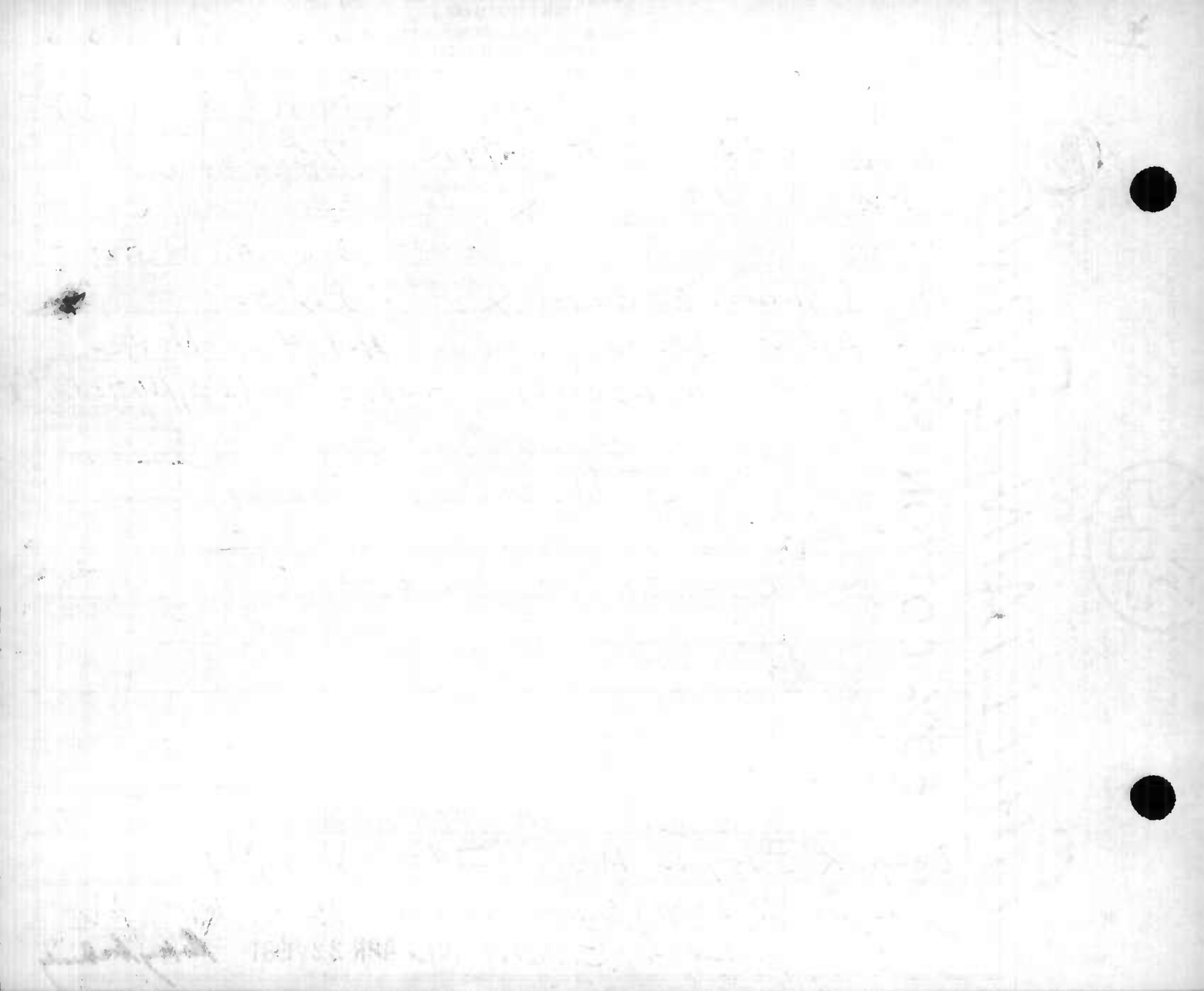
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8111566									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR <sup>35</sup> MIN <sup>35</sup>	
Vandella F. Perry								April 18, 1981		3 <sup>35</sup> P <sup>35</sup> M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		AA		5-10-1905		75 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		U.S.				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						Domestic		Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		Wicomico		Nanticoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 50			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Jacob Asbury Bandy		Addie Aletha Natter									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		099-20-6398		Gladys Barclay, Nanticoke, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probably ovarian malignancy</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
<u>Congestive Heart Failure, Phx CVA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-11-81</u> to <u>4-18-81</u> , that (I) (we) lost saw the deceased alive on <u>4-18-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>Deepak Jaggan</u>		MD				4/18/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Deepak Jaggan M.D.		52156x, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		4/23/81		Nanticoke Cem		Nanticoke, MD					
24. FUNERAL DIRECTOR		24b. DATE RECD BY REGISTRAR		24c. REGISTRAR'S SIGNATURE							
NAME		APR 22 1981		Bivallie, MD							

MEDICAL CERTIFICATION

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. IF YOU SHOULD BE FILED, WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11567	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>ANNIE LEE PETERS</b>						2b. DATE KNOWN OF DEATH <b>4-8-81</b>		2c. HOUR <b>2:15A</b>	
3. SEX <b>Female</b>	4. RACE <b>AA</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>9</b> YEAR <b>17</b> 63	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS <b>4</b> DAYS <b>17</b> HOURS <b>17</b> MIN <b>63</b>	7. BIRTHPLACE (STATE OR FOREIGN) <b>VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		9b. MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>112 Newport Circle</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CANNING</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>		12c. MD.	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>112 Newport Circle</b>		13f. MD.	
14. FATHER'S NAME FIRST <b>DOUGLAS</b> MIDDLE <b>G.</b> LAST <b>CROSELL</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELLA</b> MIDDLE <b>MAE</b> LAST <b>COLLINS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-1269146</b>		17. INFORMANT <b>ELIZ RIDEK</b>		17b. ADDRESS <b>524 TANGIER ST SALIS. MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Asphyxiation</b> IMMEDIATE CAUSE (a) <b>8902</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. MD.	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2 4-8-81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>House fire.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>own home</b>		21f. LOCATION STREET <b>112 Newport Circle</b> CITY OR TOWN <b>Salisbury</b> COUNTY <b>Wic.</b> STATE <b>Md.</b>							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>		TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER						DATE SIGNED <b>4-9-81</b>		22b. MD.	
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>		ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-13-81</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. James Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Salisbury</b> COUNTY <b>Wicomico</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>West Funeral Home, Salisbury, Md.</b>		ADDRESS <b>Salisbury, Md.</b>									

Wisconsin

Albany, 112 Newport Circle

112 Wisconsin, Albany, 112 Newport Circle

minutes

Application

10-1-01 5:00 p.m. 112

own home 112

X X

X

11-1-01

Report

100 Garden Ave., Albany, N.Y.

112 Albany, 112

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11568	
1. DECEASED NAME (TYPE OR PRINT) <b>Harry F. Pollitt</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>4-24 19 81</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-10-15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>4-24 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SALISBURY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AT HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD.</b>		13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>415 E. CHURCH ST.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM F. POLLITT</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE LeCATES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-14-4235</b>		17. INFORMANT ADDRESS <b>DONALD COLLINS SALISBURY, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4039</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ----- <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>diabetes, nephrosclerosis, hyperkalemia</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John T. Bulkeley</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>4-24-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John T. Bulkeley</b>				ADDRESS <b>Salisbury, Maryland 21801</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/28/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALISBURY, MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>LEVIN R. WILSON</b>						ADDRESS <b>SALISBURY, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 28 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Barney Bulkeley</i>	

BP

Male	White	3-10-13	66	F.	Police	4-24-61
						4-24-61

Salisbury  
 4-24-61

Cardiac arrest  
 generalized arteriosclerosis

diabetes, nephrosclerosis, hyperkalemia

John T. Bulkeley  
 Salisbury, Maryland 21801  
 Deputy  
 4-24-61

4-24-61



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>JULIAN G. POPE</b>			2a DATE OF DEATH MONTH DAY YEAR <b>APRIL 8, 1981</b>			2b HOUR <b>3:28 P.M.</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JULY 16, 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.				
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSP</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Garage Owner</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Wicomico</b> 13c CITY OR TOWN <b>Salisbury</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>S. Park Dr. EXT</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>M. Llew H. POPE</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LIZZIE MAE GIBBS</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>214-10-7094</b>		17 INFORMANT ADDRESS <b>CATHERINE MINOR POPE, SAME</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>schizophrenia heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive heart failure</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/23/81</b> , 19____, to <b>3/28/81</b> , 19____, that (we) last saw the deceased alive on <b>3/28/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Clayton L. Cadwallo</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>4/11/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clayton L. Cadwallo</b>			22e. ADDRESS <b>Louise &amp; Quinoy St's Salis. m.p. 21801</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/11/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md</b>			
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Bowels</b>			ADDRESS <b>Salisbury, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



APR 12 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Katherine, Elizabeth Porter						2a. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1981			2b. HOUR 40 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hurlock, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Flower Arranger		12b. KIND OF BUSINESS OR INDUSTRY Florist	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Regency Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Fred Willoughby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-4651		17. INFORMANT (son) ADDRESS Mr. Robert G. Porter, Salisbury, Md. Kent Circle, P.O. B 1365					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic encephalopathy.</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of Liver.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic disease of Liver.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). STATUS POST RIGHT MASTECTOMY FOR DUCTAL CARCINOMA.											
19a. DATE OF OPERATION NONE				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22-</u> 19 <u>81</u> , to <u>4-23</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/23/</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dis) (did not) view the body after death.											
22b. SIGNATURE KOTA L CHANDRASEKHARA MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-23-81.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KOTA L CHANDRASEKHARA						22e. ADDRESS SUITE 32. WESLEY DR. SALISBURY.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/24/81		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wic. Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY Funeral Home, Salisbury, Md.						ADDRESS APR 24 1981		25. DATE OF DEATH BY REGISTRAR			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8111571			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph C. Regar Jr.				2a. DATE OF DEATH MONTH DAY YEAR March 29 1981			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 6 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) Plant Manager		12b. KIND OF BUSINESS OR INDUSTRY Anchor Forge	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Del. Sussex Rehoboth Beach		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS X Camelot Park			
14. FATHER'S NAME FIRST MIDDLE LAST Ralph C. Regar Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Brennan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 188-05-1428B		17. INFORMANT ADDRESS Ann C. Regar Camelot Park Rehoboth Beach Del.			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), STATING THE UNDERLYING CAUSE, LIST: _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION 3-4-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral hemorrhage		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from 3-3-81 to 3-29-81, that (I) (we) lost saw the deceased alive on 3-29-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE E. Kent Carney				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Kent Carney, M.D.				22e. ADDRESS Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/1981		23c. NAME OF CEMETERY OR CREMATORY Lewes Presbyterian		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Delaware	
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR APR 9 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

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Salisbury, Pennsylvania (County)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Vaughn Morris Richardson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 6, 1981</b>			2b. HOUR <b>7:35 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 8 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHARMACIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sewell Richardson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Morris</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE VAPOB DATES) <b>WWI</b>			
16b. SOCIAL SECURITY NO. <b>218-12-1914</b>			17. INFORMANT ADDRESS <b>Robert A Richardson See Sec 13.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Anterior septal myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced age</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Clayton L. Roach</b>			DEGREE			22c. DATE SIGNED <b>April 7, 1981</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clayton L. Roach</b>			22e. ADDRESS <b>Locus &amp; Quiny St's Salisbury MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>4/9/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Salisbury Wicomico</b>		
24. FUNERAL DIRECTOR NAME <b>Hill-Baker-Bownds</b>			ADDRESS <b>Salisbury, MD</b>			25a. DATE RECEIVED BY REGISTRAR <b>5/15/81</b>		25b. REGISTRAR'S SIGNATURE	

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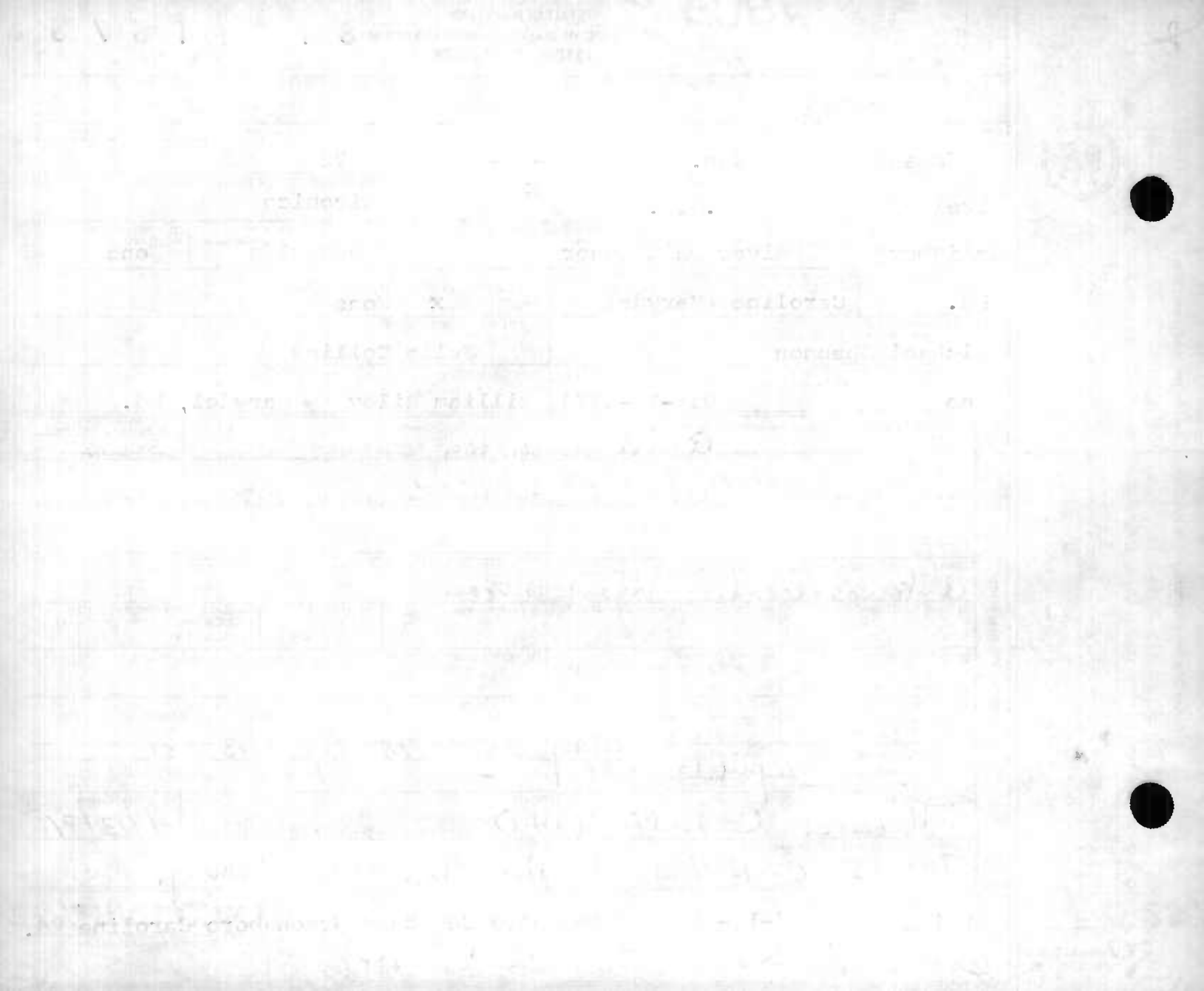


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8111573	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HANNORA</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 13 81</b>				2b. HOUR <b>5:30 A.M.</b>			
3. SEX <b>female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-25-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>River Walk Manor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Marydel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>None</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Shannon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Collins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>058-14-1374</b>		17. INFORMANT ADDRESS <b>William Riley Marydel, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>year</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic Heart Disease</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>this hospital</del> attended the deceased from <b>May 25</b> , 19 <b>78</b> , to <b>April 13</b> , 19 <b>81</b> , that <del>we</del> (we) last saw the deceased alive on <b>April 13</b> , 19 <b>81</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>if (we) (did) not view the body after death.</del>											
22b. SIGNATURE <b>Thomas C. Hill Jr</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/13/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS C. Hill Jr</b>				22e. ADDRESS <b>Pine Bluff Road, Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-15-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro Caroline Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John E. Boudin</b>				ADDRESS <b>Greensboro</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Caroline Md.</b>			

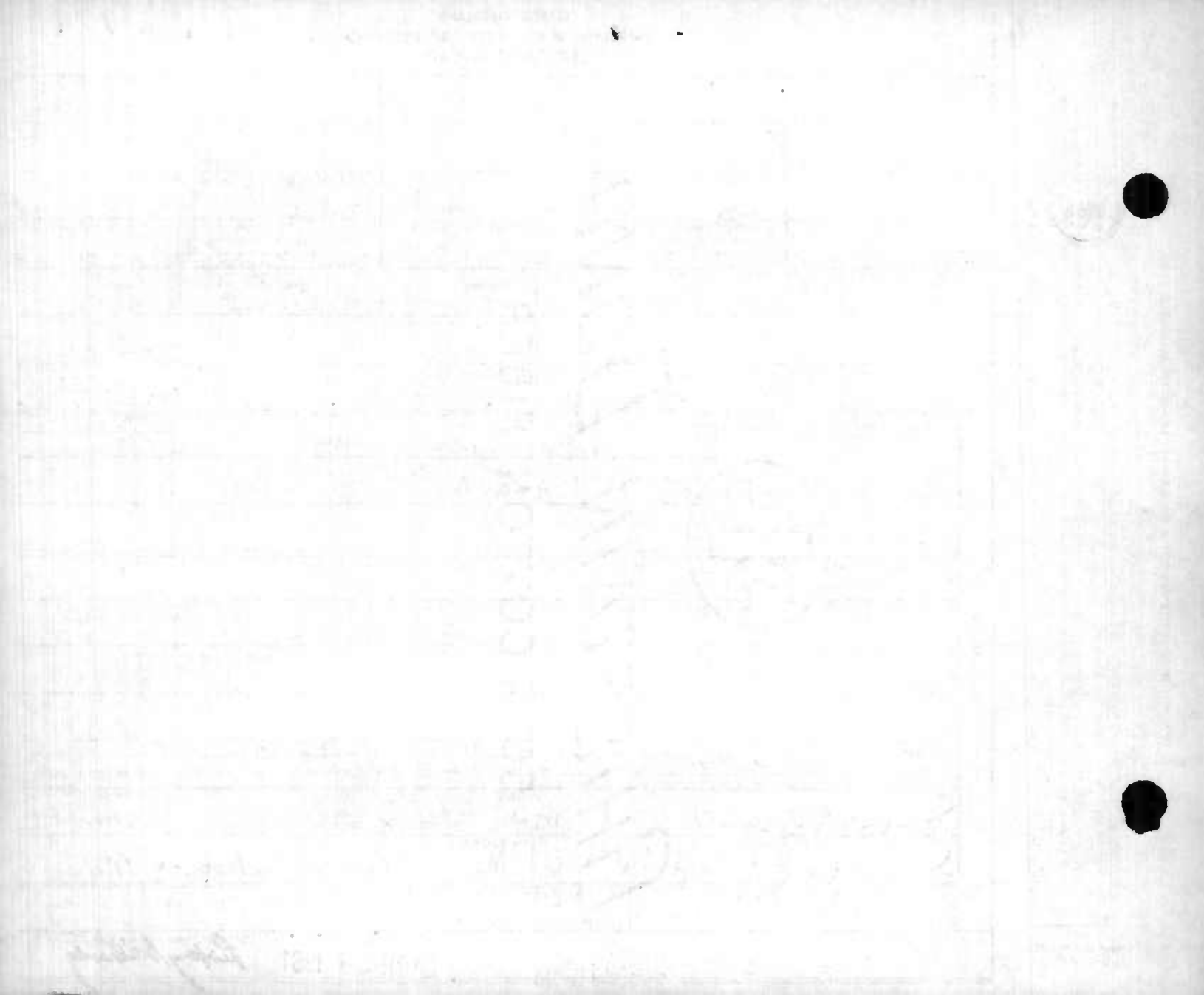


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JENNIE Sarah ROHM</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>4 25 81 12:05 pm</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 23 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO MD.</b>	
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SALISBURY NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FACTORY WORKER and Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>PARSONSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Warren</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Parsons</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>216-10-2866</b>		17. INFORMANT (son) <b>Mr. Charles R. Rohm, Rt 1 Box 124, Pittsville, Md.</b>				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricle failure</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> (c) <b>ASCVD</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-27-80</b> 19 <b>81</b> , to <b>25 Apr.</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>25 Apr.</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph C. Fitzgerald</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>25 Apr. 81</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr Joseph C Fitzgerald MD</b>				22c. ADDRESS <b>Medical Center Salisbury Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/28/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Warren Family Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>R. Pittsville, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 29 1981</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida MAY Smith			2a DATE OF DEATH MONTH DAY YEAR 4-14-81			2b HOUR 1:45 PM	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 9-21-93		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RiverWalk Manor		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY none	

13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Eden		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Rt. 1, Old Allen Road	
14 FATHER'S NAME FIRST MIDDLE LAST William F. Elliott				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Fleming					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b SOCIAL SECURITY NO. 215-38-1853D		17 INFORMANT ADDRESS Mr. Robert F. Smith (son) same as 13			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hours years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Gastritis, Generalized Arteriosclerosis							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (this hospital) attended the deceased from April 14, 1980, to April 14, 1981, that (we) last saw the deceased alive on April 14, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
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22b SIGNATURE Thomas C. Hill Jr		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/14/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. Hill Jr				22e ADDRESS Pine Bluff Road, Salisbury, Md.			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/16/81		23c NAME OF CEMETERY OR CREMATORY Siloam Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Siloam, Wicomico, Maryland	
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24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.		ADDRESS		25a DATE REC'D. BY REGISTRAR APR 23 1981		25b REGISTRAR'S SIGNATURE	
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18 + 1 =

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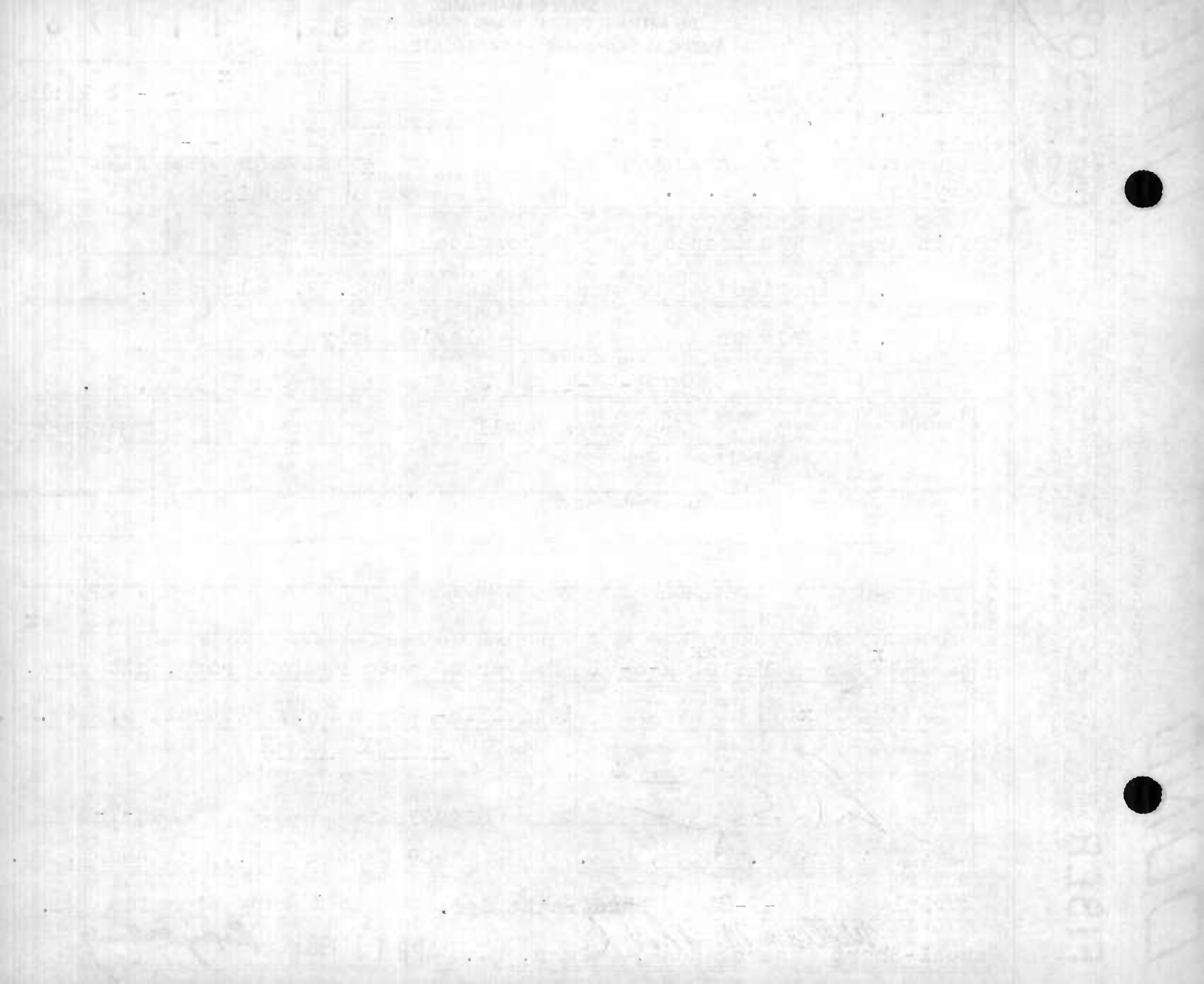
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
IVR AIS ME (5)  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11576	
1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR JAMES STEININGER</b>										2a. DATE KNOWN OF DEATH <b>4-7-81</b> 12:10A	
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3 19 63</b>		6. AGE (IN YEARS) <b>18</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Delmar</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 3, Melson Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Keith E. Steininger</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gloria Perry</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>221-56-1116</b>		17. INFORMANT ADDRESS <b>Jessie Steininger Delmar, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>8150</b> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>11:10M. 4-6-81</b>				21b. TIME OF INJURY <b>11:10M. 4-6-81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto ran off road, hit tree.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>		21f. LOCATION <b>Pittsville-Melson Rd., Pittsville, Wic. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Earl L. Royer</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER DATE SIGNED <b>4-7-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-9-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR NAME <b>William M. Short</b> ADDRESS <b>Marvel-Short Funeral Home, Delmar, De.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 13 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 1 5 7 7		
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Ella B. STEVENS										April 25, 1981		2:33p M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White		4 29 94		86						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Wicomico MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)										
Salsbury		Deer's Head Center										
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Management		Hotel										
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland				Dorchester		Hurlock				North Main Street		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST Robert Wachter				FIRST MIDDLE LAST Ellen Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No				-		315 S. Main St. C. Malcolm Stevens Hurlock, MD 21643						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Asxv D cardiac fib + CHF</u>												
4292 DUE TO, OR AS A CONSEQUENCE OF (b)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE				DEGREE				22c. DATE SIGNED				
E. P. RITCHINGS M. D.				MP				4/25/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS								
E. P. RITCHINGS M. D.				Deer's Head Center, Salsbury, Md. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		4-28-81		Unity Washington		Hurlock, Dorchester, MD						
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Zeller Funeral Home, East New Market, MD				MAY 6 1981				[Signature]				

1905

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11578			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERTHA -- TACKETT</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>4-6-81</b>		2b. HOUR MIN <b>2:14 PM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/1/1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4-6-81</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Secretary Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Fruitland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>421 W. Main Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ike Russell</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie Belle Stapleton</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>243-01-9970</b>		17. INFORMANT ADDRESS <b>same as 13</b> <b>Mr. Russell Tackett (husband)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>4-7-81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wic. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>						25a. DATED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

BP \_\_\_\_\_



12-7-1

Wm. A. Smith

Wm. A. Smith, Jr.

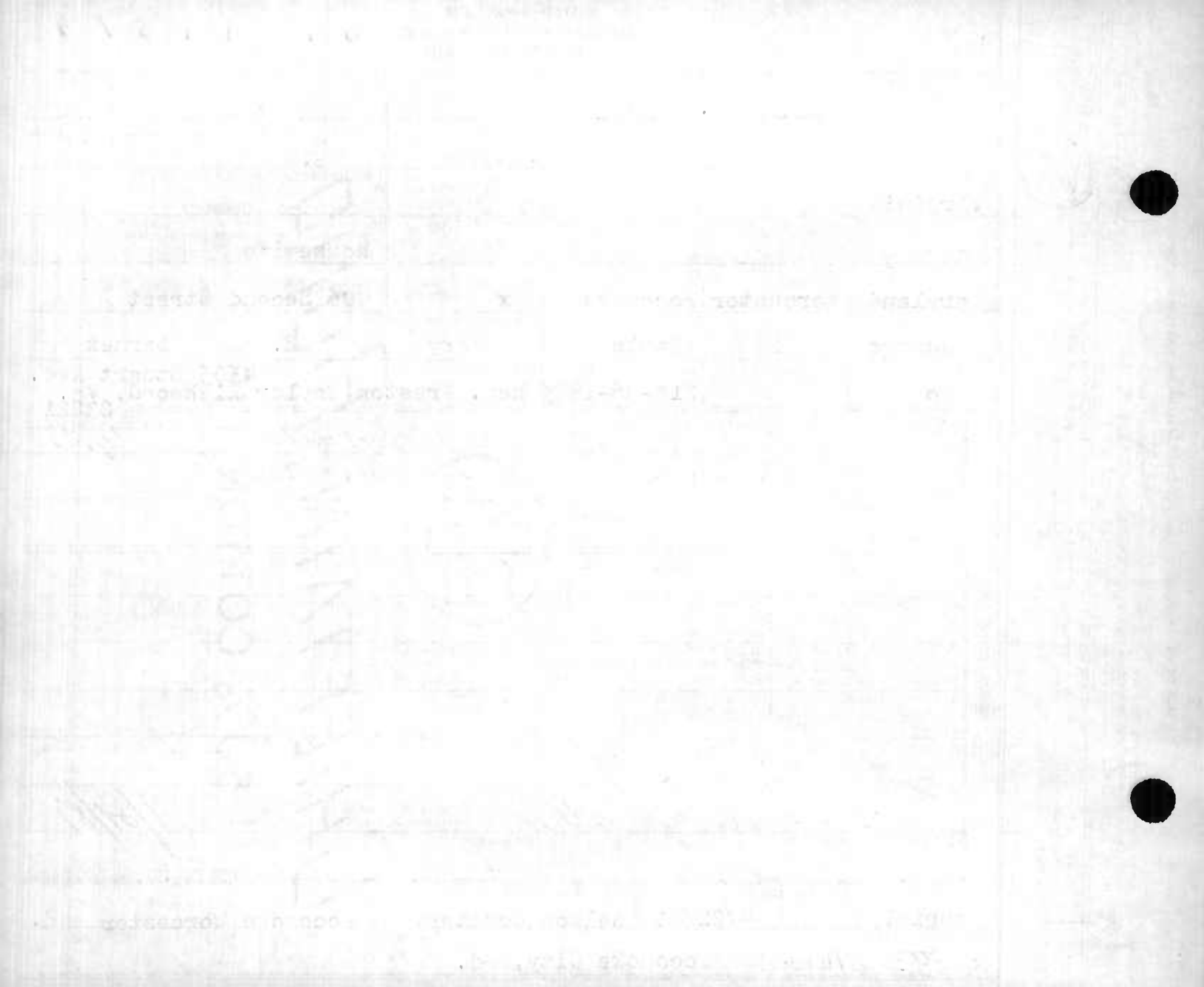
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 1 5 7 9		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace P. TAYLOR					2a. DATE OF DEATH MONTH DAY YEAR 4-20-81				2b. HOUR 4:05PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8-15-99		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.						
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland					13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 906 Second Street	
14. FATHER'S NAME FIRST MIDDLE LAST George E. Parks					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Barnes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 215-36-1885		17. INFORMANT ADDRESS 4505 Stuart Ave. Rev. Preston Taylor Richmond, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of colon with metastasis</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE PERIOD BETWEEN ONSET AND DEATH 1 yr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/81</u> to <u>4/20/81</u> , that (I) (we) lost <u>4/19/81</u> saw the deceased alive on <u>4/19/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)												
22b. SIGNATURE <u>Dr. Earl M. Beardsley</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/21/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY					22e. ADDRESS CIVIC AVE. RT. 50 SALISBURY, MD. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/22/81		23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.					
24. FUNERAL DIRECTOR NAME Scott S. Nelson					ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR APR 27 1981		25b. REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 81 11580							
1. DECEASED NAME (TYPE OR PRINT) Elijah W. Truitt					2a. DATE OF DEATH MONTH DAY YEAR APRIL 10 1981			2b. HOUR 9:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS 4 10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hoistal				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Ralston Purina Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John Truitt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Short				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT ADDRESS Doris May Taylor Salis., Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>lung carcinoma with Brain</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>4/9</u> 19 <u>81</u> , to <u>4/10</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/9/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-13-81		23c. NAME OF CEMETERY OR CREMATORY Firemans Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Sharptown Wicomico Md.		
24. FUNERAL DIRECTOR NAME William M. Short				25a. DATE REC'D. BY REGISTRAR APR 14 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
26. FUNERAL HOME Marvel-Short Funeral Home Delmar, Del.									



INSTITUTIONAL INFORMATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS OCCUR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE UNDERTAKER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

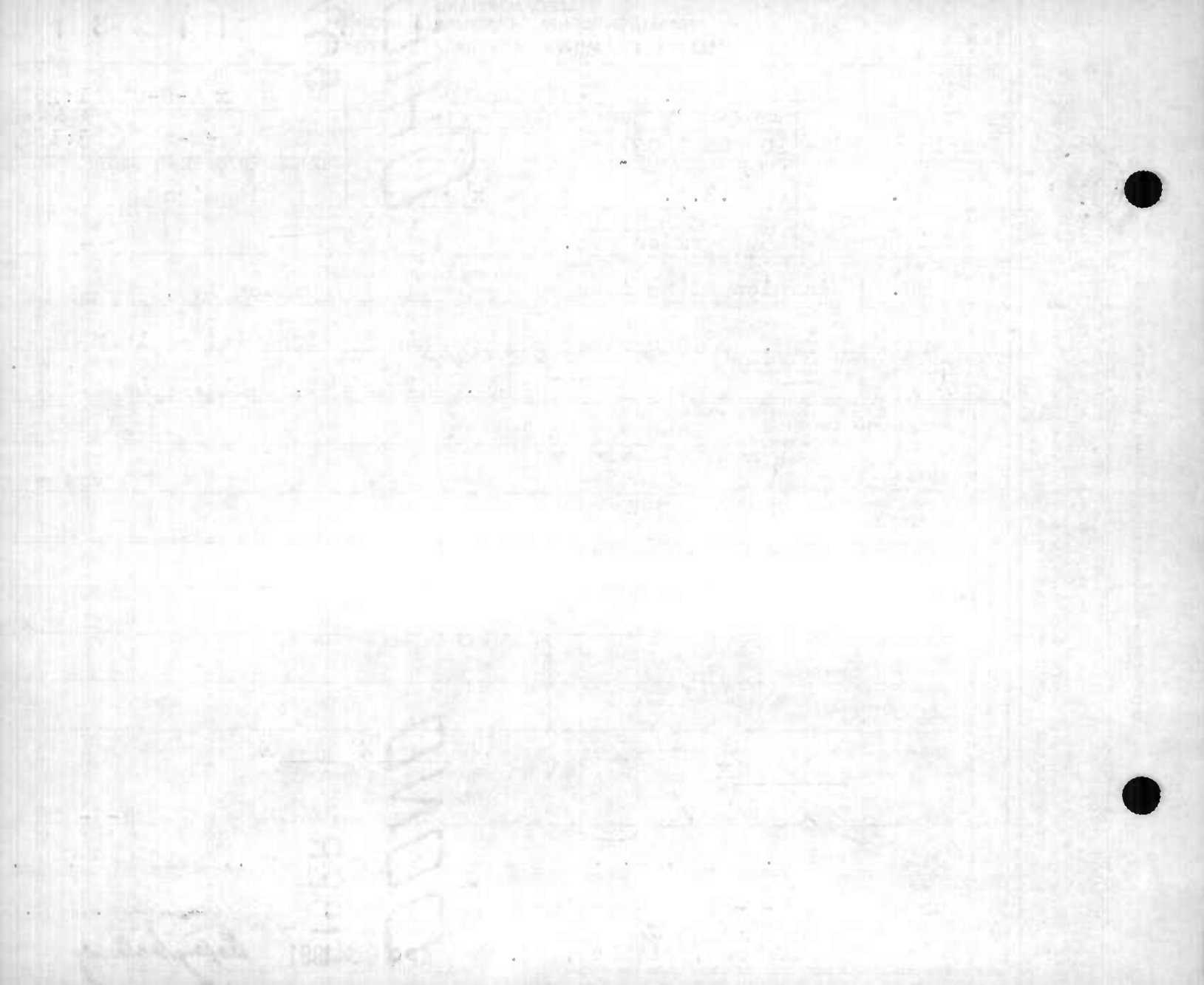
DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DOLLIE E. WAINWRIGHT</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4-2-81, 1:20 P.M.			2b. HOUR		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 06 1893</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>87 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>4-2-81 19 3:15 P.M.</b>	2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>507 Camden Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>507 Camden Ave.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George B. Robertson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie Virginia Palmer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT (son) ADDRESS <b>Salisbury, Md. Wm. Wainwright, Loblolly Lane,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>			TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>4-3-81</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>			ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>4-4-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park, Salisbury, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Messick Funeral Home, Bivalve, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 28 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Harvey M. ...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	1	5	8	2
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Casper Elmer WALLER					2a. DATE OF DEATH MONTH DAY YEAR April 17, 1981					2b. HOUR 8:45 A.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1905			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Harrington, Del.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.								
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Construction						
13a. STATE Maryland					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2325 Hudson Drive					
14. FATHER'S NAME FIRST MIDDLE LAST Harry E. Waller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Mary Catwell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-10-9136		17. INFORMANT (brother) #2 Oyster Shell Lane Mr. Houston E. Waller, Bivalve, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of prostate</u> 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1975						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17/81</u> to <u>4/17/81</u> , that (I) (we) saw the deceased alive on <u>4/17/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)																
22b. SIGNATURE Inja J. Hwang, M.D.					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/17/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/20/81		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Md.								
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE [Signature]								

BP

10-17-1947

collected

not collected



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James Harvey Weatherly</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 17, 1981</b>		2b. HOUR <b>6:30 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 22, 1909</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		13a. STREET ADDRESS <b>Spring Hill Rd.</b>			
13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harvey Weatherly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Barkley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>214-32-0649</b>		17. INFORMANT ADDRESS <b>Spring Hill Rd. Salisbury, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 1850 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <b>Adenocarcinoma of prostate</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>April 79</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic congestive heart failure</b>					
19a. DATE OF OPERATION <b>June 80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Orchiectomy for carcinoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <b>March 1970</b> to <b>present</b> , that (I) (we) last saw the deceased alive on <b>3-6-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Walter De Vault Jr.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/21/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter De Vault Jr.</b>		22e. ADDRESS <b>Medical Center Salisbury Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-20-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Keith G. DeWinton - Accomac, Virginia</b>			
25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11584			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA B. WEBB										DATE ESTIMATED MONTH DAY YEAR 4-19-81		3 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 9 06		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-19-81			
9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home			
10. CITY OR TOWN OF DEATH Salisbury				13a. STATE De.				13b. COUNTY Sussex		13c. CITY OR TOWN Delmar			
14. FATHER'S NAME FIRST MIDDLE LAST John Handy Melson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Workman				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 222-26-8821			
17. INFORMANT ADDRESS Harold L. Webb rdt Delmar, Del 19940				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Epidermoid Carcinoma of the Cervix APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours months years				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 4-20-81	
ACTUAL SIGNATURE				EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 4/22/81		23c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Delaware			
24. FUNERAL DIRECTOR NAME Homer Disharoon, Laurel, De.				25a. DATE REC'D. BY REGISTRAR APR 23 1981				25b. REGISTRAR SIGNATURE					

X

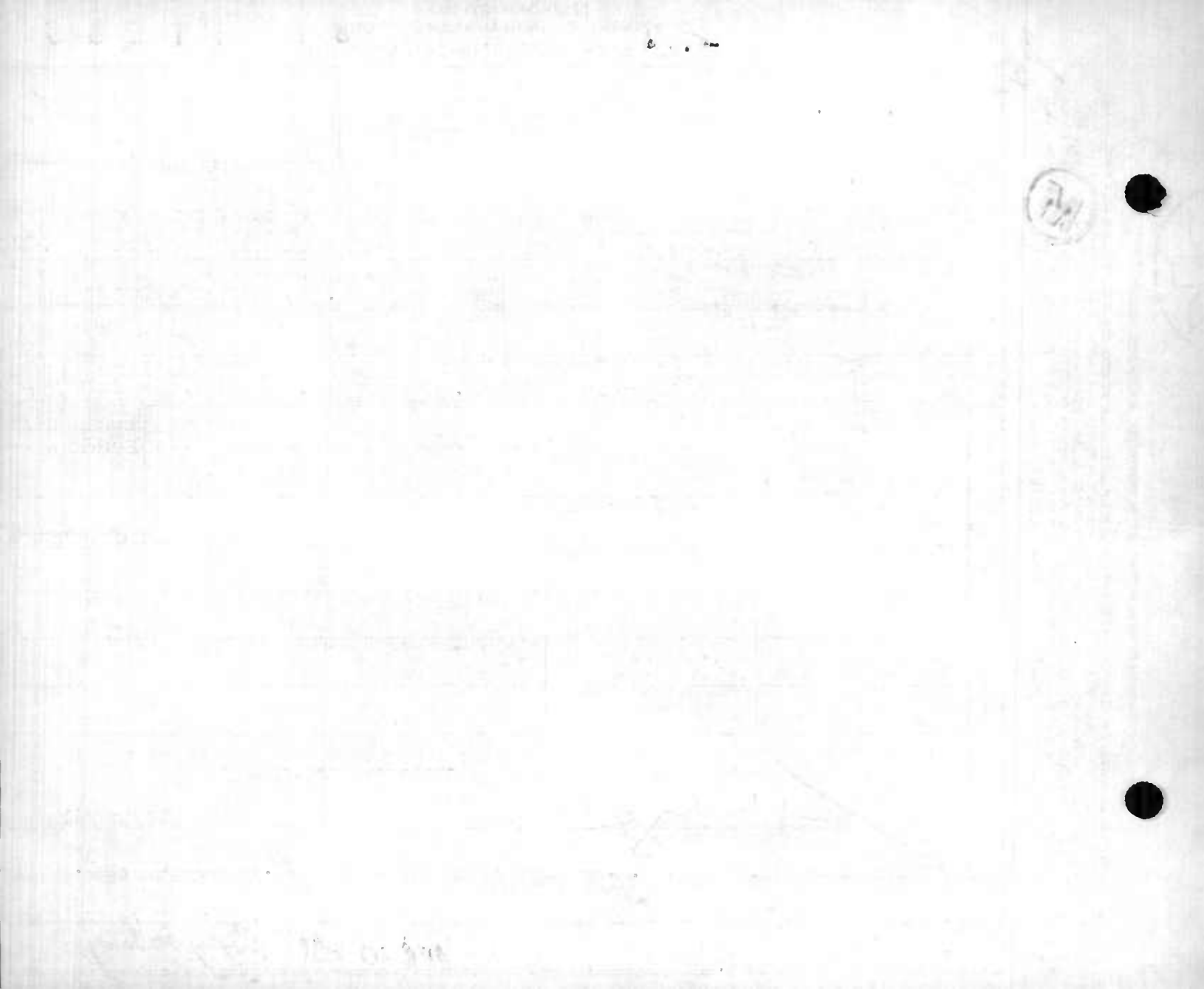
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHM-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11585	
1. DECEASED NAME (TYPE OR PRINT) <b>Beulah Katherine Webster</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> <b>4/16/81</b>		2b. HOUR <b>A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>30</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <b>April 16, 1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at home - Airport Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Mfg. Co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 3, Airport Road</b>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Bishop</b> LAST <b>Smith</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Ann</b> LAST <b>Pruitt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-03-2234</b>		17. INFORMANT <b>Mr. Raymond E. Hudson, Salisbury, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>4:16 P.M. 4/16/81</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Earl L. Royer</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>4/17/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/20/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>				23d. LOCATION CITY OR TOWN <b>Salisbury</b> COUNTY <b>Wicomico</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 20 1981</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 5 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donna M. WEST				2a. DATE OF DEATH MONTH DAY YEAR April 15 1981		2b. HOUR 8:22 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1963		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Bishopville	
14. FATHER'S NAME FIRST MIDDLE LAST Lee West		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Bernsteel		13d. STREET ADDRESS Rt. 1 Box 79A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 243-17-5357		17. INFORMANT ADDRESS Lee West Bishopville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ependymoma of brain</u> 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. P. Ritchings, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/16/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Ritchings, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 19, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Anne's		23d. LOCATION CITY OR TOWN COUNTY STATE Phoenixville Chester PA	
24. FUNERAL DIRECTOR NAME Hastings Funeral Home				ADDRESS Selbyville, DE		25a. DATE REC'D. BY REGISTRAR APR 21 1981	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 1 1 5 8 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH				2b HOUR			
Lillian Lee Whayland				4-10-81				10:25PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		11-09-00		80 YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Wicomico County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Salisbury Nursing Home				Seamstress		Shirt Mfg. Co.			
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland				Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		321 Beaglin Park Drive	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Alpheus Lee Elliott				Mary Sophia Wright							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No				214-10-7845		Mrs. T. Catherine Dennis (daughter)		same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>myocardial infarction</i> (c) <i>hypertension</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROPRIATE PERSONAL BETWEEN DEATH 4 days cys.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>arteriosclerotic heart disease</i>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <i>4/9</i> 19 <i>80</i> , to <i>4/10</i> 19 <i>81</i> , that (1) (we) lost <i>above</i> the deceased on <i>4/9</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.				22b. SIGNATURE <i>Dr. Earl M. Beardsley</i> DEGREE <i>MD</i>				22c. DATE SIGNED <i>4/10/81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Dr. Earl M. Beardsley				Civic Ave. & Rt. 50, Salisbury, Md. 21801							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/14/81		Parsons Cemetery		Salisbury, Wicomico Md.			
24 FUNERAL DIRECTOR NAME				24b. ADDRESS				25. DATE RECEIVED BY REG.		25b. RECEIVED BY	
HOLLOWAY FUNERAL HOME, Salisbury, Maryland								APR 16 1981		<i>Dr. Earl M. Beardsley</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>COLON J White</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22, 1981</b>		7b. HOUR <b>5<sup>40</sup> P. M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>AA</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 12-1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD</b>
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>M.D.</b>		13b. COUNTY <b>SOMERSET</b>		13c. CITY OR TOWN <b>PR. ANNE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROGER W. WHITE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SHELLIE SMITH</b>		16. ADDRESS <b>RE. 3. Box 319, PRINCESSANNE MD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>0</b>		16b. SOCIAL SECURITY NO. <b>215-16-8764</b>		17. INFORMANT <b>SHELLIE WHITE, RE. 3. Box 319, PR. ANNE MD</b>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINS</b>	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Thrombosis</b>		<b>DAYS</b>	
(c) <b>Arteriosclerotic Cardiovascular Disease</b>		<b>YRS</b>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> 19 <b>81</b> , to <b>4/22</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <b>Donald M. Wood</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/22/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD M. WOOD MD</b>				22e. ADDRESS <b>QUINCY E LOCUST STS. SALISBURY, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>4-25-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winton, Somerset MD</b>	
24. FUNERAL DIRECTOR NAME <b>Adelphiemo</b> ADDRESS <b>407 Somerset Ave. Pr. Anne</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE - CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Dean WIGGINS Jr.					2a. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1981			2b. HOUR 10 <sup>45</sup> M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager Ins.		12b. KIND OF BUSINESS OR INDUSTRY Adjusting		
13a. STATE Maryland					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST W. D. Wiggins, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Buena Waters					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mrs. Eleanor W. Wiggins (wife)		ADDRESS same as 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction of the heart.</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Chronic Obstructive Pulmonary Disease</i> <i>Bronchitis</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) (this hospital) attended the deceased from <i>3-9-81</i> to <i>4-23-81</i> , that (I) (we) last saw the deceased alive on <i>4-23-81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>James L. Chifford</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-23-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. CHIFFORD MD.				22e. ADDRESS #12 MEDICAL CENTER Salisbury MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/27/81		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE RECEIVED BY REGISTRAR APR 27 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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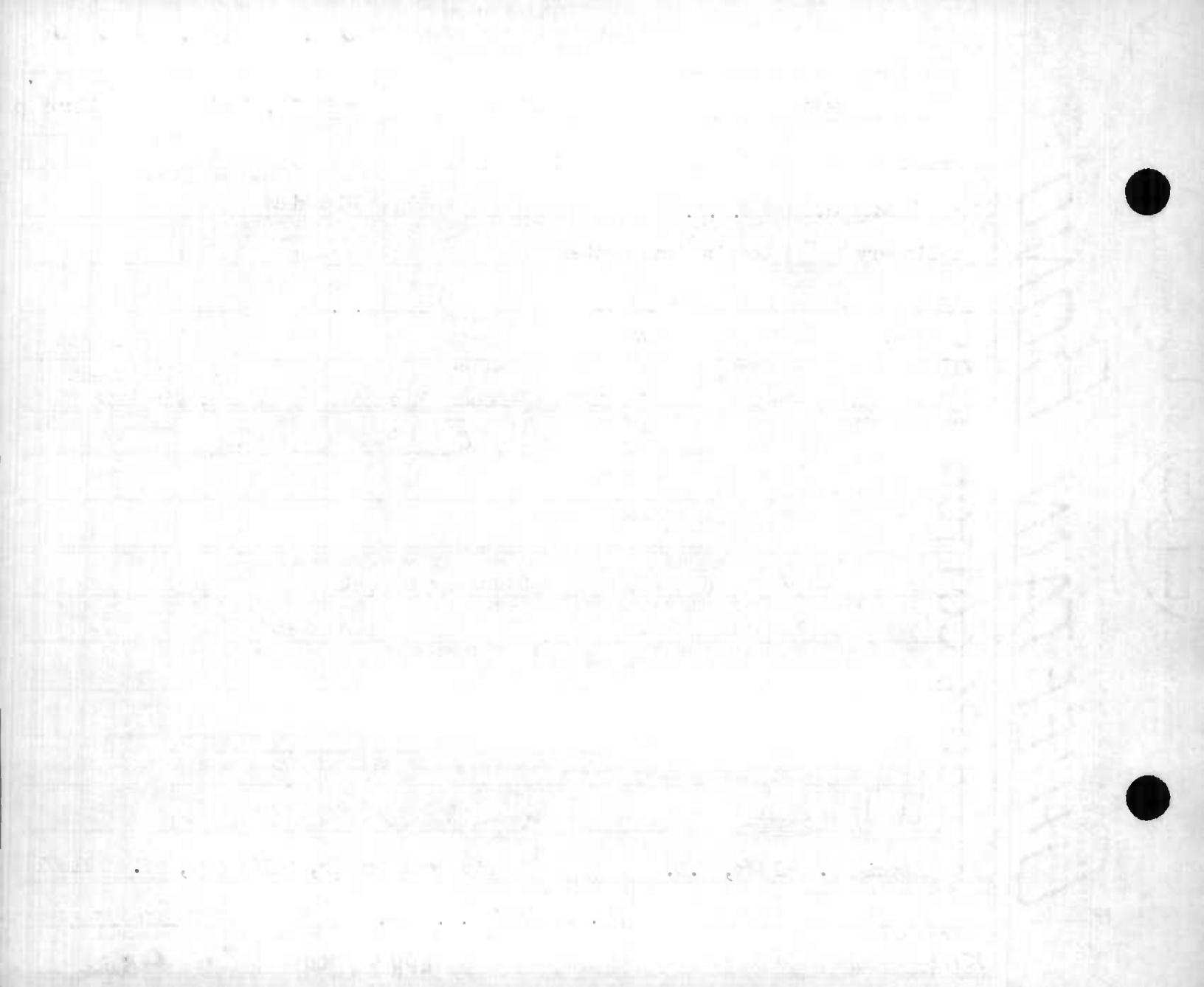
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 5 9 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Edith Rock WILLIAMS				April 16, 1981				11:05 <sup>PM</sup>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		1 26 97		84 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Fruitland, Md.		U.S.A.				Wicomico MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Deer's Head Center				retired					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Wicomico		Fruitland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 387	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Edward Rock				Annie Polliott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no				215-16-3249		Rebecca Newsome		673 Bell Street Hampton, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
4029 IMMEDIATE CAUSE (a)										X	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
CVA c. 1980 hemiplegia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Leonid V. Maldve, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
				Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				4/22/81		MT. CALVARY U.M. CEM. FRUITLAND		CITY OR TOWN COUNTY STATE			
						WICOMICO MARYLAND					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
JOILEY MEMORIAL CHAPEL				APR 27 1981				P. H. B. B. B.			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11591			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William O Young</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <b>4-23 81</b>										2b. HOUR <b>1046</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 <b>4-23 81</b>										2d. HOUR <b>1046</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>										MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Medical Ct.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>							
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Bishopville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 386</b>													
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond Young</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora Fogle</b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W.W. II 220-07-8244</b>		17. INFORMANT ADDRESS <b>Irma B. Young, Bishopville, MD</b>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9554</b> IMMEDIATE CAUSE (a) <b>gunshot wound- head</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs.</b>									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>(b)</div> <div>(c)</div> </div>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Epidermoid Carcinoma-floor of mouth</b>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 P.M. 4-22 81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Daye Rd. Bishopville, Worcester MD</b>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>John T. Bulkeley</i>										TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>4-23-81</b>										
EXAMINER'S NAME (TYPE OR PRINT) <b>John T. Bulkeley, M.D.</b> ADDRESS <b>Salisbury, Maryland 21801</b>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/26/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bishopville, Wor., MD</b>													
24. FUNERAL DIRECTOR NAME <b>Hastings Funeral Home, Selbyville,</b>										25a. DATE REC'D. BY REGISTRAR <b>DE APR 29 1981</b>			25b. REGISTRAR'S SIGNATURE <i>L. J. McCreedy</i>										

William  
Male White 5 6 10 25  
Young  
Wisconsin

Peninsula General Medical Co. Wisconsin  
P.O. Box 108  
Lansing, Michigan  
J.W. II  
gunshot wound - head

Epidermoid Carcinoma-floor of mouth  
4-22-21  
Self inflicted  
Daye Rd. Bishopville, Wisconsin

John T. Bakerley, M.D.  
Salisbury, Maryland 21801  
4-22-21  
Bishopville, Maryland